

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06398**

6414

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		d. STREET ADDRESS 400 Eastern Blvd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400 Eastern Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUBY E ABRAHAM				4. DATE OF DEATH Month Day Year June 7 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-93	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Adams				14. MOTHER'S MAIDEN NAME Nanny Low			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Husband (Same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Art. Scler. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 min 15 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-7-61	
EXAMINER'S NAME (Type) JACK C. COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-10-61	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) Balto.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				ADDRESS 418 Eastern Blvd.		24a. REC'D BY REGISTRAR DATE JUN 8 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Harris

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 45 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2606 Lauretta Avenue (23) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) CHARLES B. AFFAYROUX		4. DATE OF DEATH Month June Day 12 Year 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1915		9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 61		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer				10b. KIND OF BUSINESS OR INDUSTRY Hospital				13. FATHER'S NAME Frank J. Affayroux				14. MOTHER'S MAIDEN NAME Lydia Murphy											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 219-05-7477				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (b) CARCINOMA, PANCREAS WITH CARCINOMATOSIS (c) DUODENAL ULCER											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH RECENT				UNKNOWN											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that VA (this hospital) attended the deceased from April 28 to June 12 , 1961, that W (we) last saw the deceased alive on June 12 , 1961, and that death occurred at A.M. from the causes and on the date stated above.																							
22a. SIGNATURE Thomas F. Crahan								22b. DATE SIGNED 6/12/61															
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.								22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-15-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery				23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14				ADDRESS 6009 Harford Rd., Balto. 14				25a. REC'D BY REGISTRAR JUN 14 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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06400

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN lb 1 1/2 mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY First ALLEN Middle ALLEN Last				4. DATE OF DEATH Month 6 Day 24 Year 1961			
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3. 11. 1917	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME SUMTER ALLEN				14. MOTHER'S MAIDEN NAME ROZIE ISAAC			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (?)		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) For advanced pulmonary tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 5. 9. 1961 to 6. 24. 1961 , that (I) (we) last saw the deceased alive on 6. 24. 1961 , and that death occurred at 8 PM , from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 6. 24. 1961			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-28-61		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				25a. REC'D BY REGISTRAR Rockville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hance	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please
explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06401

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 21 MD</u> d. STREET ADDRESS <u>11624 Dorsey Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Phillip Amrhein</u> First Middle Last 4. DATE OF DEATH <u>June 4 1961</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-5-07</u> 9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber - sup.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Inspector</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Philip Amrhein</u> 14. MOTHER'S MAIDEN NAME <u>Augusta Scifers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>216-10-872</u> 17. INFORMANT <u>Wife (same as above)</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cor. Thromb. - sudden</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>2</u> (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik</u> EXAMINER'S NAME (Type) <u>FRANK T. KASIK</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/4/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>6-8-61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u> ADDRESS <u>418 Eastern Blvd.</u> 24a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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ALABAMA STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

AMERICAN MEDICAL BOARD

STATE OF ALABAMA
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON.
Name of Deceased Person _____
Age _____
Sex _____
Date of Death _____
Place of Death _____
Cause of Death _____
Manner of Death _____
Signature of Medical Examiner _____
City _____ State _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6418
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06402

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home				d. STREET ADDRESS 14 W. 2nd Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Arkuszewski Last				4. DATE OF DEATH Month June Day 24 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1889	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man				10b. KIND OF BUSINESS OR INDUSTRY Seaboard Asphalt			
11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John Arkuszewski				14. MOTHER'S MAIDEN NAME Rosalie Golombowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-05-4036			
17. INFORMANT Mrs. Catherine Arkuszewski				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC CHANGES IN CEREBRAL VESSELS DUE TO (c) HYPERTENSION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/1 19 61 to 6/24 19 61 , that (I) (we) last saw the deceased alive on 6/24 19 61 , and that death occurred at 12:00 PM from the causes and on the date stated above.							
22a. SIGNATURE John H. Shaw				22b. DATE June 26, 1961			
22c. PHYSICIAN'S NAME (Type) John H. Shaw				22d. ADDRESS 5800 Edmondson Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 28, 1961			
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.				23d. LOCATION (City, town, or county) (State) Mitchie Hwy. A. A. Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce				25a. REC'D BY REGISTRAR June 27 '61			
25b. REGISTRAR'S SIGNATURE George J. Gonce				25c. REGISTRAR'S SIGNATURE George J. Gonce			

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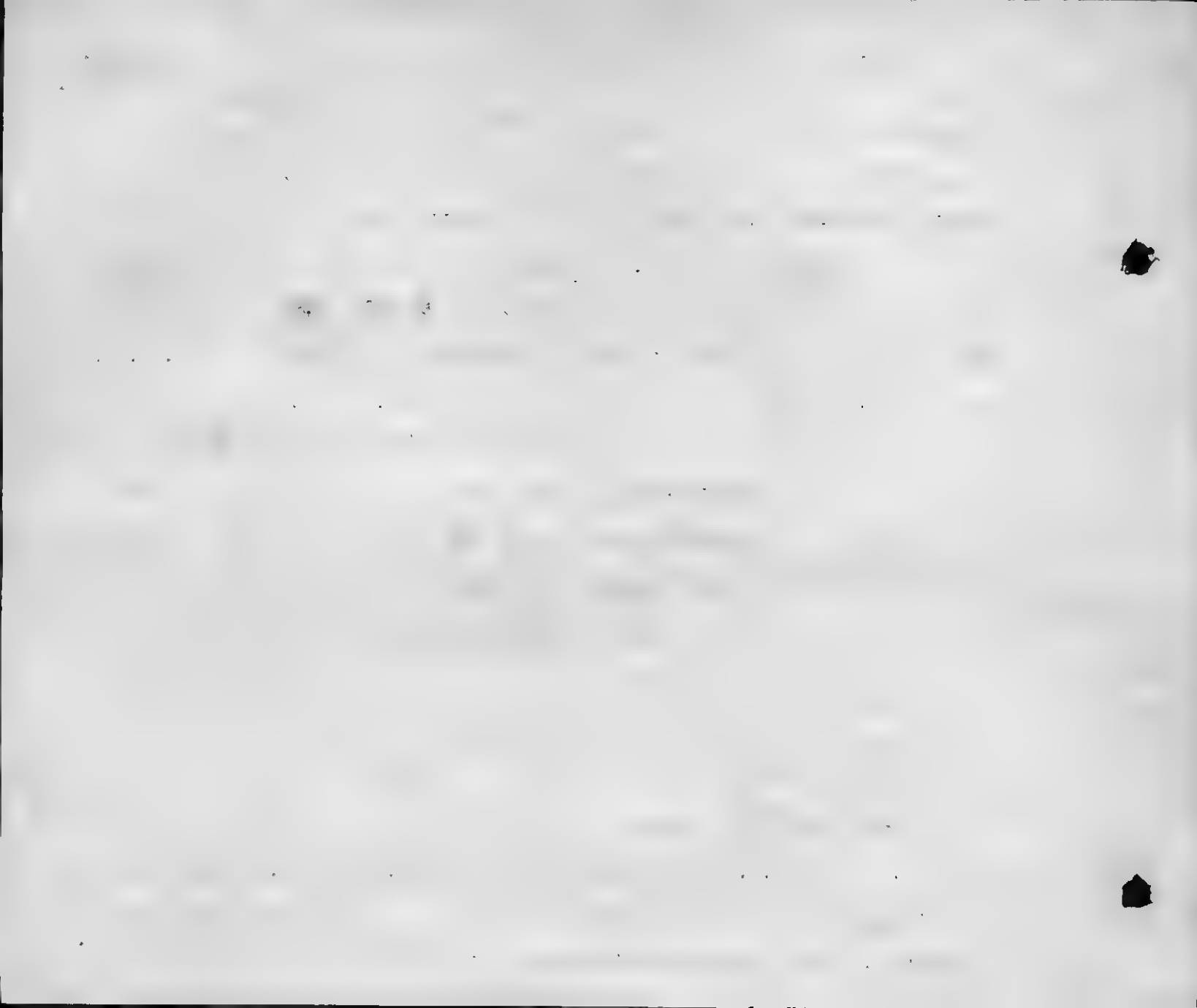
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6419 Item 23b, Film G-290 7/5/61 jwk				06403							
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1120 Arran Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HOMER J. ARNREICH				4. DATE OF DEATH June 26 1961				9. AGE (In years last birthday) 69 yrs.			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store				11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland			
13. FATHER'S NAME Ferdinand M. Arnreich				14. MOTHER'S MAIDEN NAME Charlotte A. Johnston				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 219-10-0752				17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 541.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. XXX DUE TO (b) BLEEDING PEPTIC ULCER, DUODENUM (c) PORTAL CIRRHOSIS OF LIVER				INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ARTERIOSCLEROTIC HEART DISEASE Duration unknown											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (For nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTO. 18, MD., FT. HOWARD DIVISION			
20f. (City or town) Baltimore				20g. (County) Maryland				20h. (State) Maryland			
21. I certify that (X) (this hospital) attended the deceased from June 17 1961 to June 26 1961 , that (X) (we) last saw the deceased alive on June 26 1961 , and that death occurred at 9:15 M., from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan				22b. DATE SIGNED 6/26/61				22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 29, 1961				23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery			
23d. LOCATION (City, town or county) Baltimore				23e. (State) Maryland				23f. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck & Son, 5305 Harford Rd., Balto.				24a. ADDRESS 14, Md.				24b. DATE JUN 28 '61			
24c. REGISTRAR'S SIGNATURE Arthur S. Kraus				24d. REGISTRAR'S SIGNATURE Arthur S. Kraus				24e. REGISTRAR'S SIGNATURE Arthur S. Kraus			



in by the funeral director, or by the attending physician and completely in page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

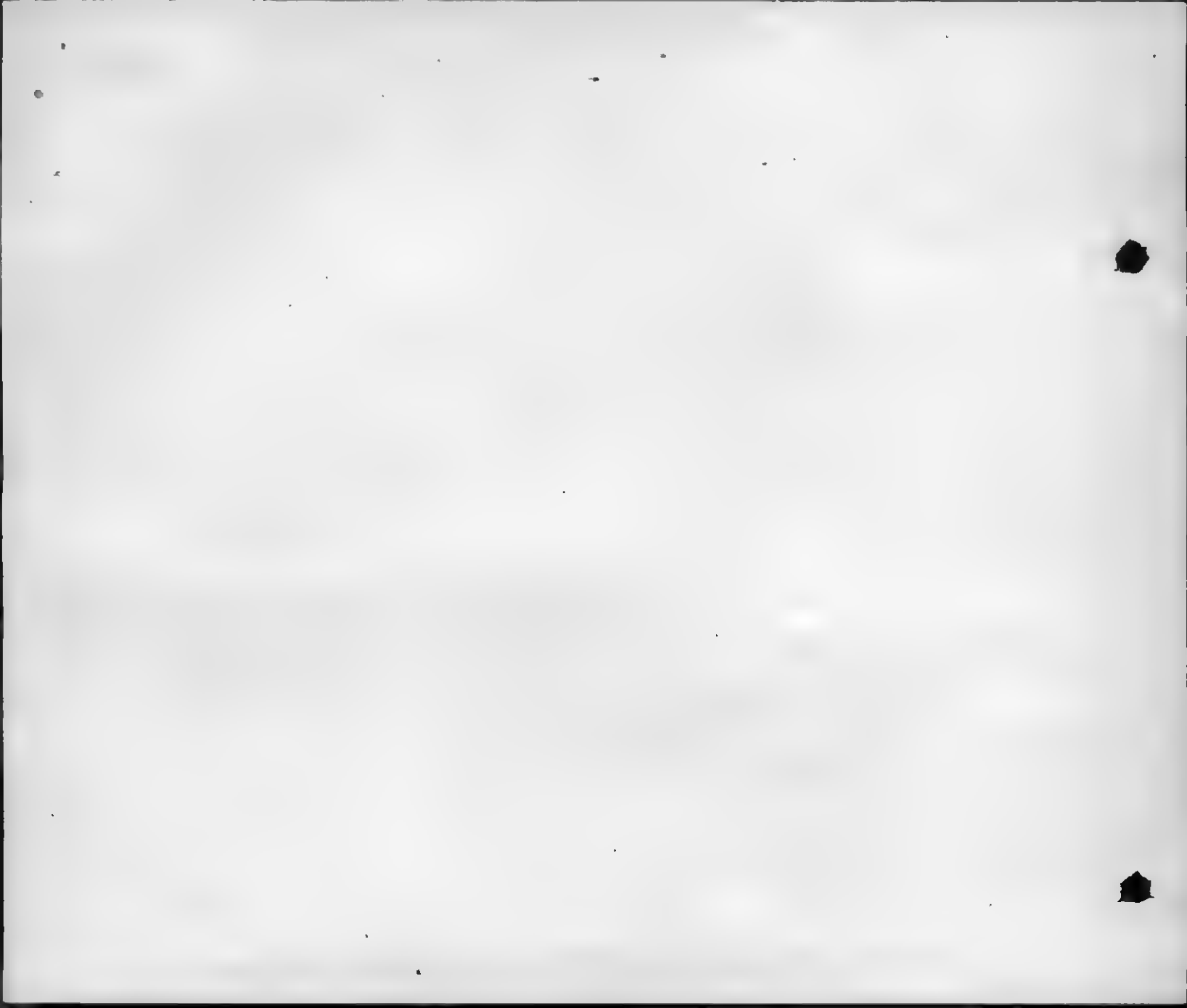
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06404

06404

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>2 days</u>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown, Md.</u> d. STREET ADDRESS <u>421 Grand Oak Ave. 12070</u>	
3. NAME OF DECEASED (Type or print) <u>JEANNETTE A. AUERBACH</u>		4. DATE OF DEATH <u>June 8 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Byer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>clothes</u>	11 BIRTHPLACE (State or foreign country) <u>New York City</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Adler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>9ms. Betty Strauss Baltimore, Md.</u>	
17. INFORMANT <u>Ms. Betty Strauss</u>		Address <u>Baltimore, Md.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Myocardial Decompensation</u> DUE TO (c) <u>Chronic Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>6-6-61</u> to <u>6-8-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-8-61</u> and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a SIGNATURE <u>James G. Saffell</u>		22b DATE SIGNED <u>6-8-61</u>	
22c PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d ADDRESS <u>Reisterstown, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Univ Hosp</u>		23b DATE THEREOF <u>June 9/61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of U. Hosp.</u>		23d LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Sol. Levinson & Bros. Inc. 6010 Reist Rd</u>		25a REC'D BY, REGISTRAR <u>JUN 13 '61</u>	
25b REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>			



1
FOR STATE
HEALTH DEPT.

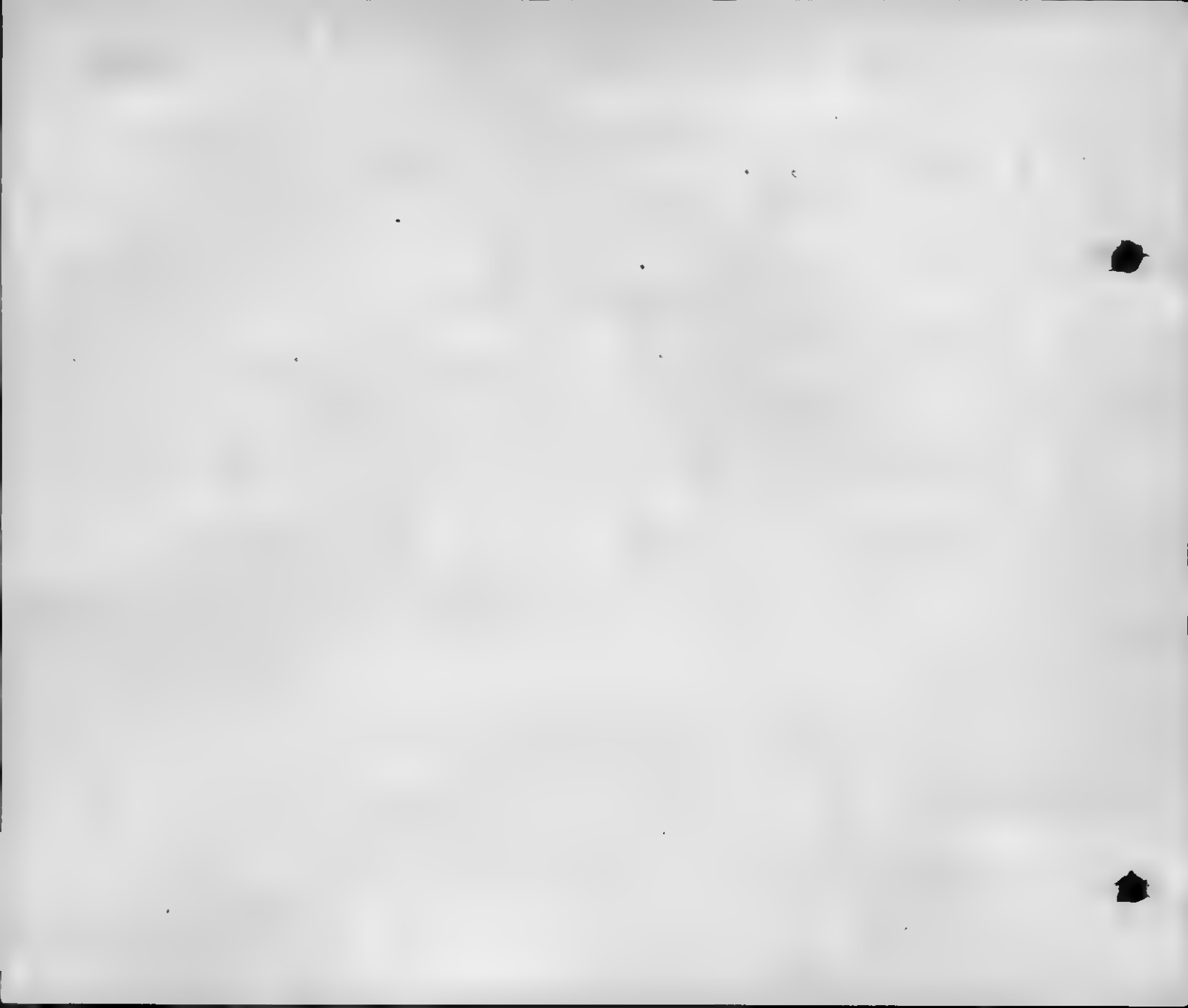
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, place "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06405

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point 19, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethlehem Steel Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1237 N. Potomac Street</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph J. Baker</u>		4. DATE OF DEATH <u>June 9 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pump Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u>	
13. FATHER'S NAME <u>William Baker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schafer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-09-1576</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>16 years</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack E Collins</u>		DATE SIGNED <u>6-10-61</u>	
EXAMINER'S NAME (Type) <u>Jack E Collins</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faithy</u>	22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR NAME (Type) <u>Charles E. Schimunek Funeral Home</u> ADDRESS <u>3331 Brehms Lane</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

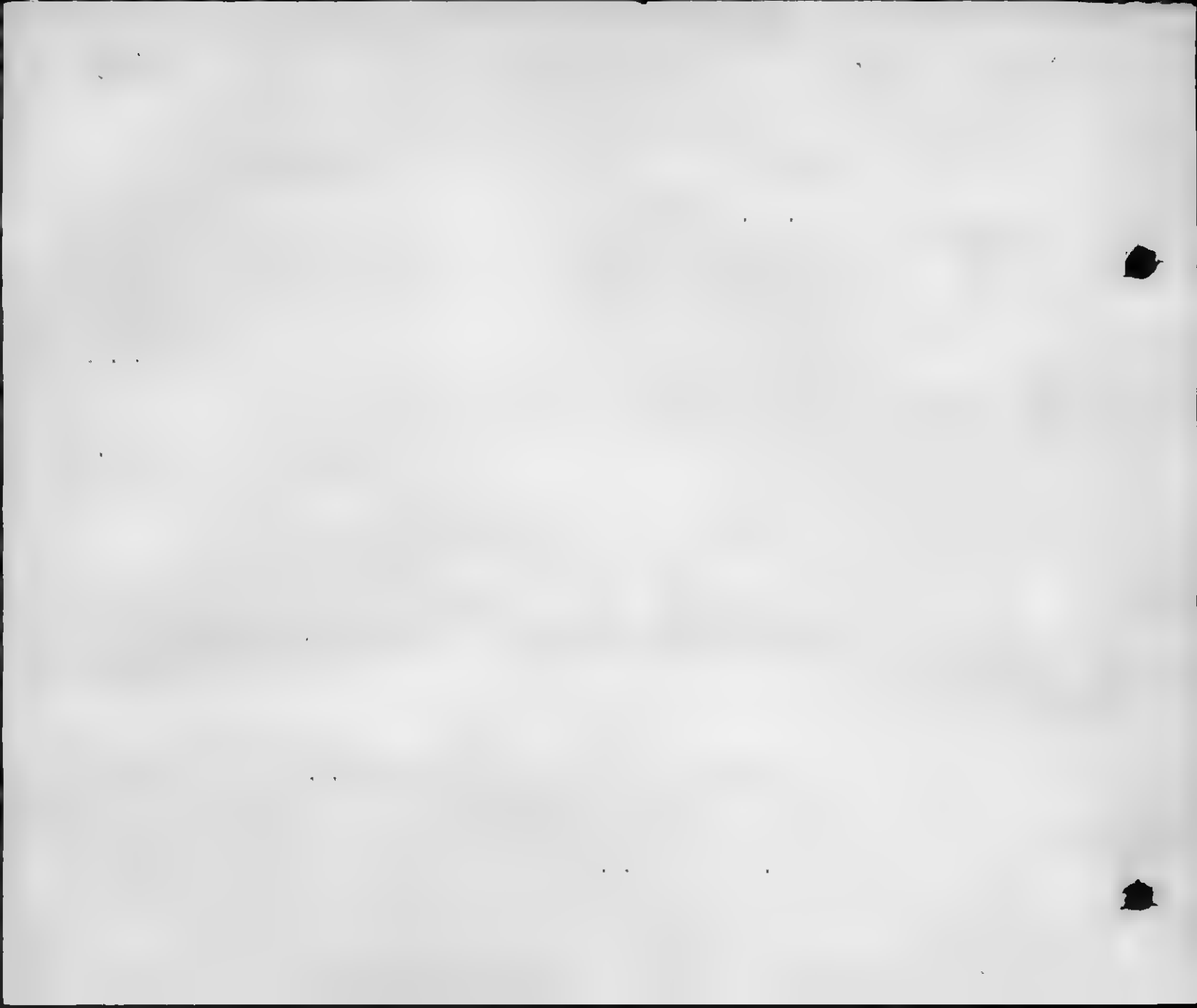
06406

M

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> 33 yrs. c. LENGTH OF STAY N 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood St. Tr. School</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>Unknown</u>			
3. NAME OF DECEASED (Type or print) <u>Katie</u> First <u>Barlege</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>3/29/1878</u>			
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Maryland</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Rosewood Records, Owings Mills, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infarction of myocardium due to arteriosclerotic coronary thrombosis</u> (b) <u>Arteriosclerotic heart disease</u> (c) <u>Arteriosclerotic heart disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive vascular disease with cardiac failure (compensated)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>12-31-</u> p.m. <u>12-31-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12-31-</u> , 19 <u>27</u> to <u>6-5-</u> , 19 <u>61</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6/5/</u> , 19 <u>61</u> , and that death occurred at <u>9:30</u> , <u>PM</u> on the causes and on the date stated above.							
22a. SIGNATURE <u>Edward J. Mathews</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u>		22d. ADDRESS <u>Rosewood State Training School</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>			
23d. LOCATION (City, town or county) <u>Owings Mills Md.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. L. ...</u>		ADDRESS <u>Rosewood State Training School</u>		25a. REC'D BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE <u>...</u>		DATE <u>JUN 14 '61</u>		25c. REGISTRAR'S SIGNATURE <u>...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



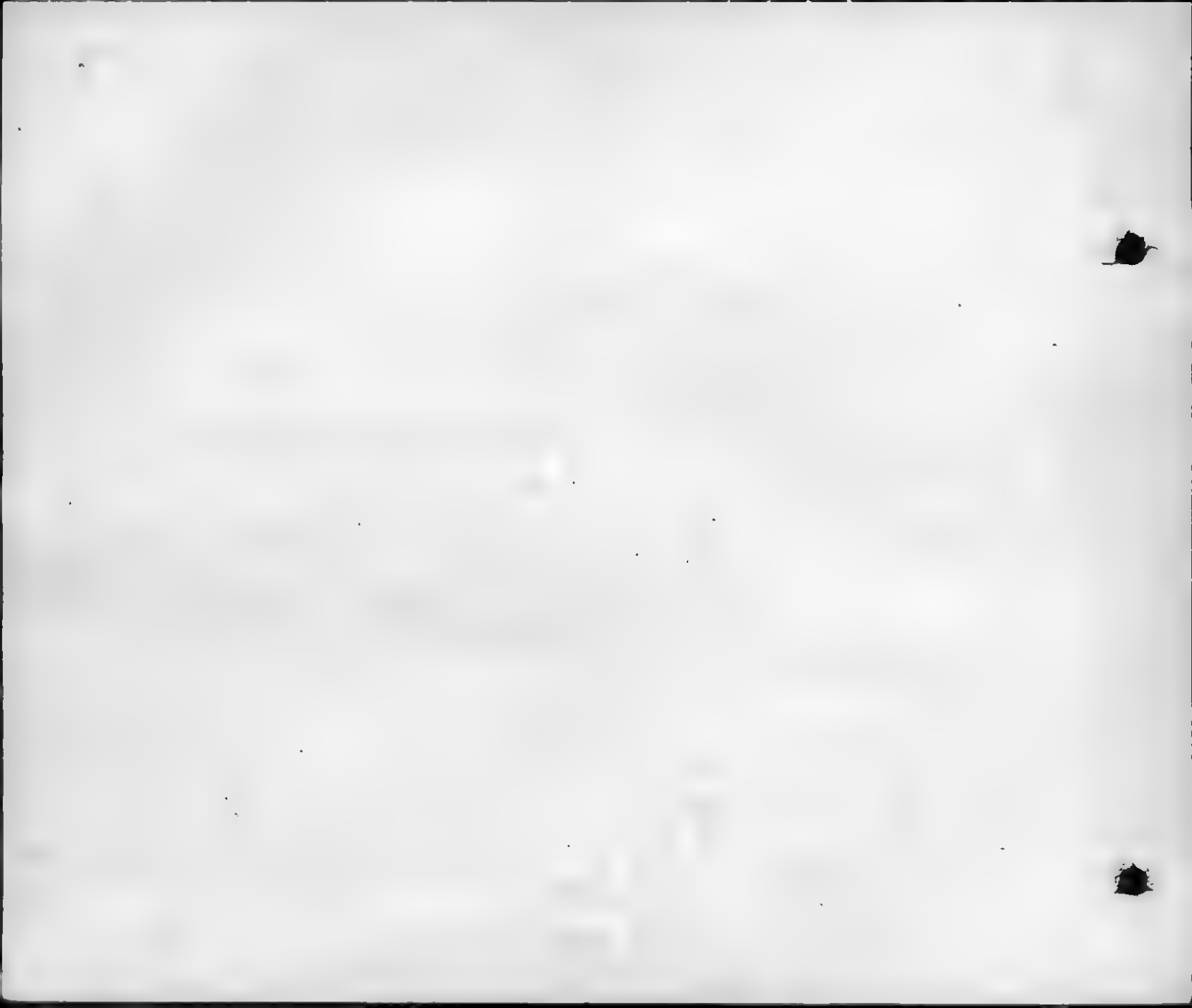
423
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06407

1 PLACE OF DEATH a. COUNTY BENT NURSING HOME REISTERSTOWN MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE BALTO. b. COUNTY Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b May 23, 1961	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BENT NURSING HOME 12020 REISTERSTOWN RD.		d. STREET ADDRESS 1104 STODDARD CT.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Blanche Middle BARNES Last BARNES		4. DATE OF DEATH Month 6 Day 21 Year 1961	
5 SEX F.	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 12, 1887
9 AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR: Months 11 Days 13	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY and	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17 INFORMANT Charles Barnes 1104 Stoddard		Address er	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 192.1 DUE TO Edema Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis with Dilatation DUE TO (c) Arteriosclerotic Cardio-Vascular Disease Unknown		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none; Parkinsonism		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 25, 1961 , to June 21, 1961 , that (I) (we) last saw the deceased alive on June 19, 1961 , and that death occurred at 7:55 A.M. from the causes and on the date stated above			
22a. SIGNATURE George C. McElroy		22b. DATE SIGNED June 21, 1961	
22c. PHYSICIAN'S NAME (Type) George C. McElroy Md		22d. ADDRESS 230 Main St., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-24-61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Mount Auburn		23d. LOCATION (City, town, or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert S. Nelson		25a. REC'D BY REGISTRAR 26 61	
25b. REGISTRAR'S SIGNATURE Robert S. Nelson			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

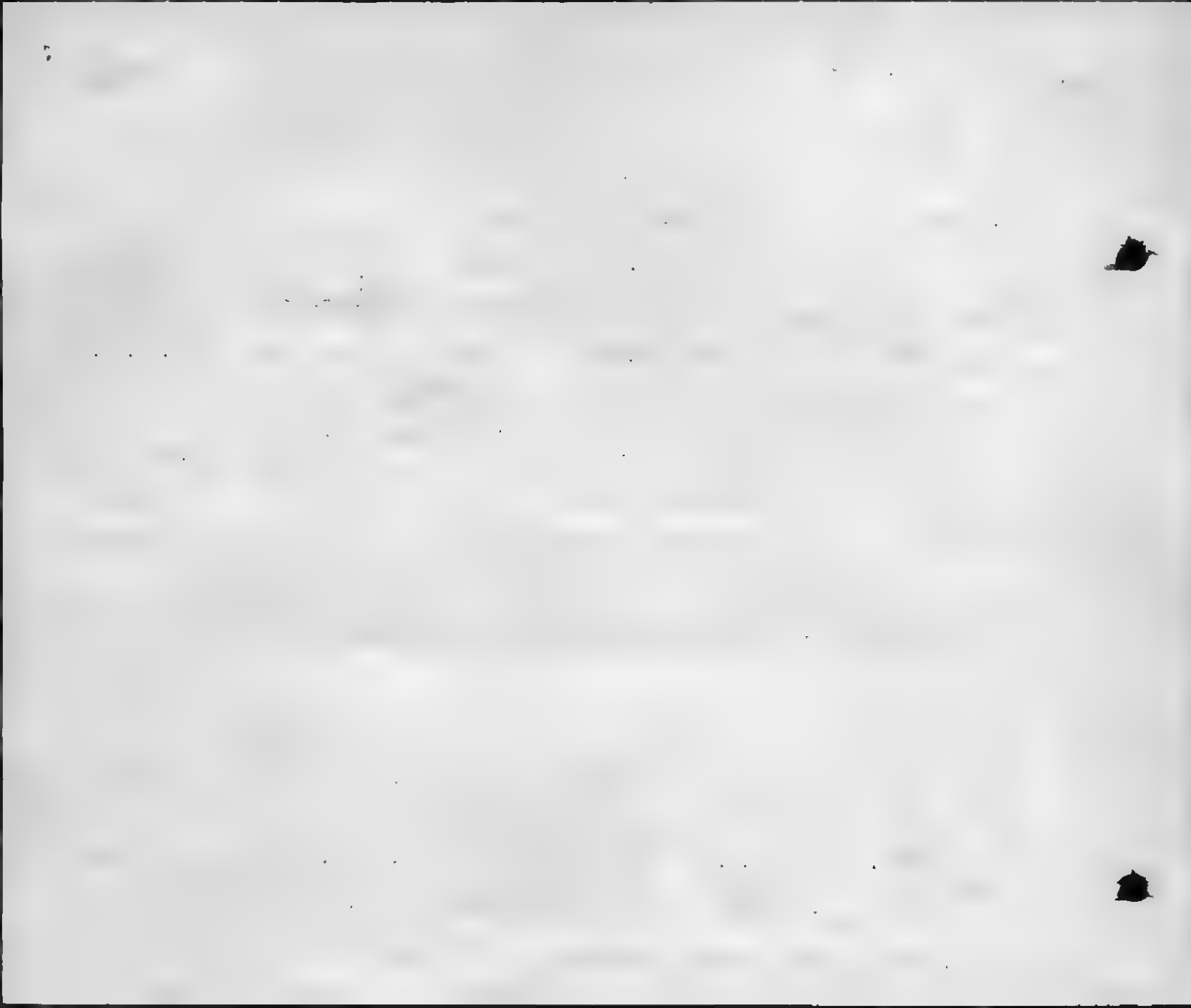
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06408

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN IL <u>212 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u> d. STREET ADDRESS <u>Route #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN M. BARNES</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1901</u> 9. AGE (in years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Frederick County, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joshua T. Barnes</u>		14. MOTHER'S MAIDEN NAME <u>(Martha) Bertha Boone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u> <u>215-18-7392</u>		16. SOCIAL SECURITY NO. <u>215-18-7392</u> 17. INFORMATION <u>Clinical Records, VAH, Baltimore 18, Md. FORT HOWARD DIVISION</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) <u>METASTATIC CARCINOMATOSIS</u> DUE TO (c) _____ Condition, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>SURGICAL ABSENCE, RIGHT KIDNEY (CARCINOMA, RIGHT KIDNEY)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that <u>JOH</u> (this hospital) attended the deceased from <u>November 28, 1960</u> , to <u>June 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1961</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Crahan</u> M.D.		22b. DATE SIGNED <u>6/29/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>		22d. ADDRESS <u>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-1-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Methodist Church</u>		23d. LOCATION (City, town or county) (State) <u>Carroll County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Waltz Funeral Home, Winfield, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Carlton E. Hume</u>	

YR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06409

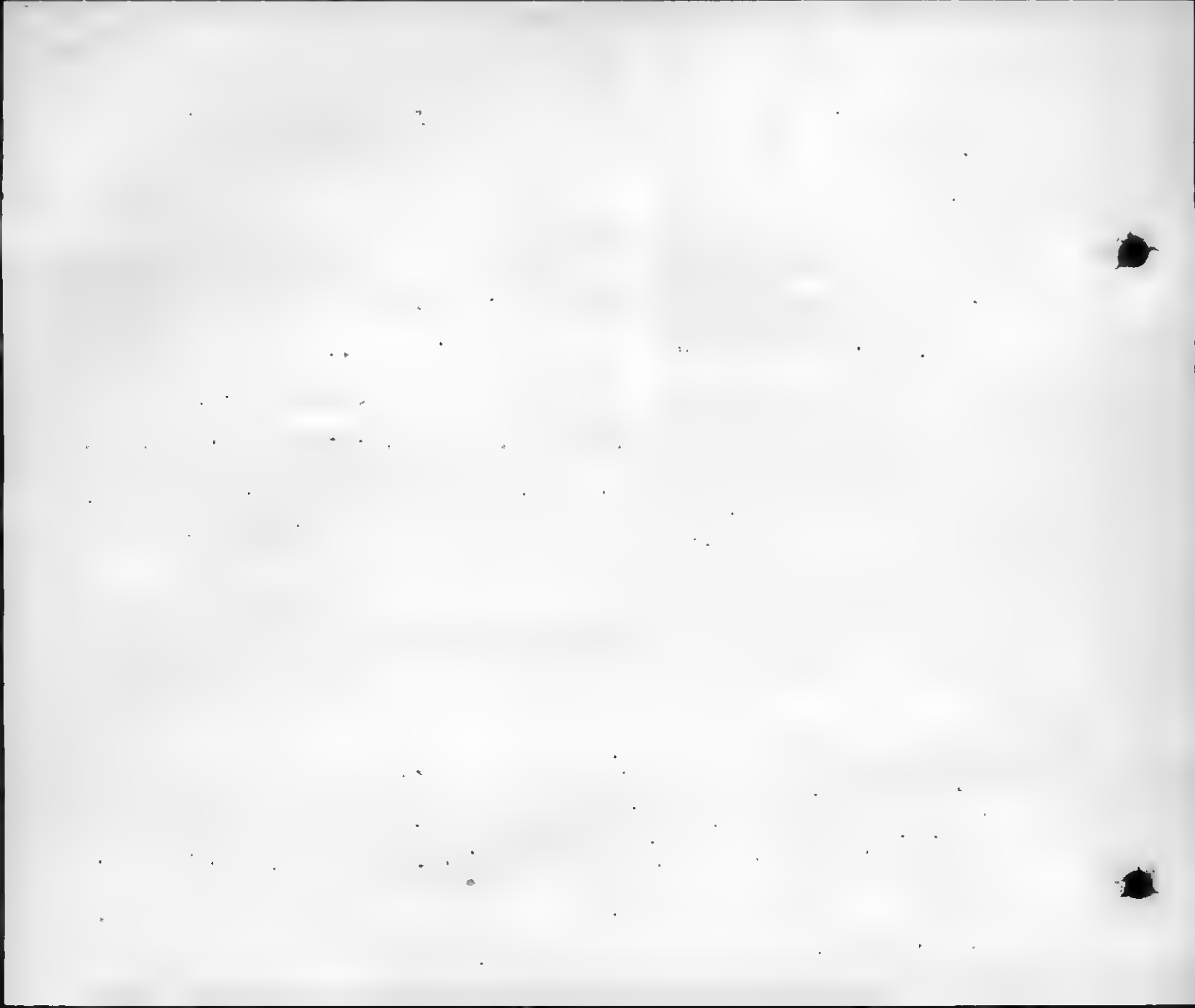
0425

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Pennsylvania b. COUNTY York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				d. STREET ADDRESS 77			
3. NAME OF DECEASED (Type or print) First MARY Middle ALMA Last BEATTY				4. DATE OF DEATH Month June Day 11 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1881		9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months 8 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Edward Beatty				14. MOTHER'S MAIDEN NAME Margaret Rebecca Pocock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 195-26-8052		INFORMANT Address Miss. Lela M. Beatty Glenarm, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 7-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Cardiovascular Sclerosis DUE TO (c) 10 y INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 11, 1961 , to June 11, 1961 , that I last saw the deceased alive on June 11, 1961 , and that death occurred at 11:58 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) FORK MD. DATE SIGNED ACTUAL SIGNATURE Clifford F. Hudson, M.D. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON FORK MD.							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/1961		22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Rutledge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz Jarrettsville Md.				24a. REC'D BY REGISTRAR JUNE 13 '61		24b. REGISTRAR'S SIGNATURE William E. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0426

06410

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN (b) <u>27 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smyrna</u> d. STREET ADDRESS <u>36 Mt. Vernon Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>PAUL</u> First Middle Last		4. DATE OF DEATH <u>June 14 19 61</u> Month Day Year		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 16, 1921</u> Yrs. Months Days		9. AGE (In years last birthday) <u>39</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Lee County, Kentucky</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Perry Begley</u>				14. MOTHER'S MAIDEN NAME <u>Birdie Jones</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word or dates of service) <u>Yes WW II</u> 16. SOCIAL SECURITY NO <u>400-14-9752</u> 17. INFORMANT <u>Clinical Records VA Hospital, Baltimore 18, Md. Fort Howard Division</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC EMBRYONAL CARCINOMA, WIDESPREAD (PRIMARY SITE: TESTIS)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOPNEUMONIA, TERMINAL</u> (c) <u>PEPTIC ULCER, DUODENUM</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from <u>May 18 19 61</u> to <u>June 14 19 61</u> that (X) (we) last saw the deceased alive on <u>June 14 19 61</u> and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Thomas F. Crahan</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/15/61</u>							
22c. PHYSICIAN'S NAME (Type or print) <u>THOMAS F. CRAHAN, M.D.</u>				22d. ADDRESS <u>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Camp Nelson National</u>		23d. LOCATION (City, town or county) (State) <u>Nicholasville, Kentucky</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Shipped to
 Betts & West Funeral Home, 404 N. Main St. Nicholasville, Ky.

SYSTEM 12

5

CERTIFICATE OF DEATH

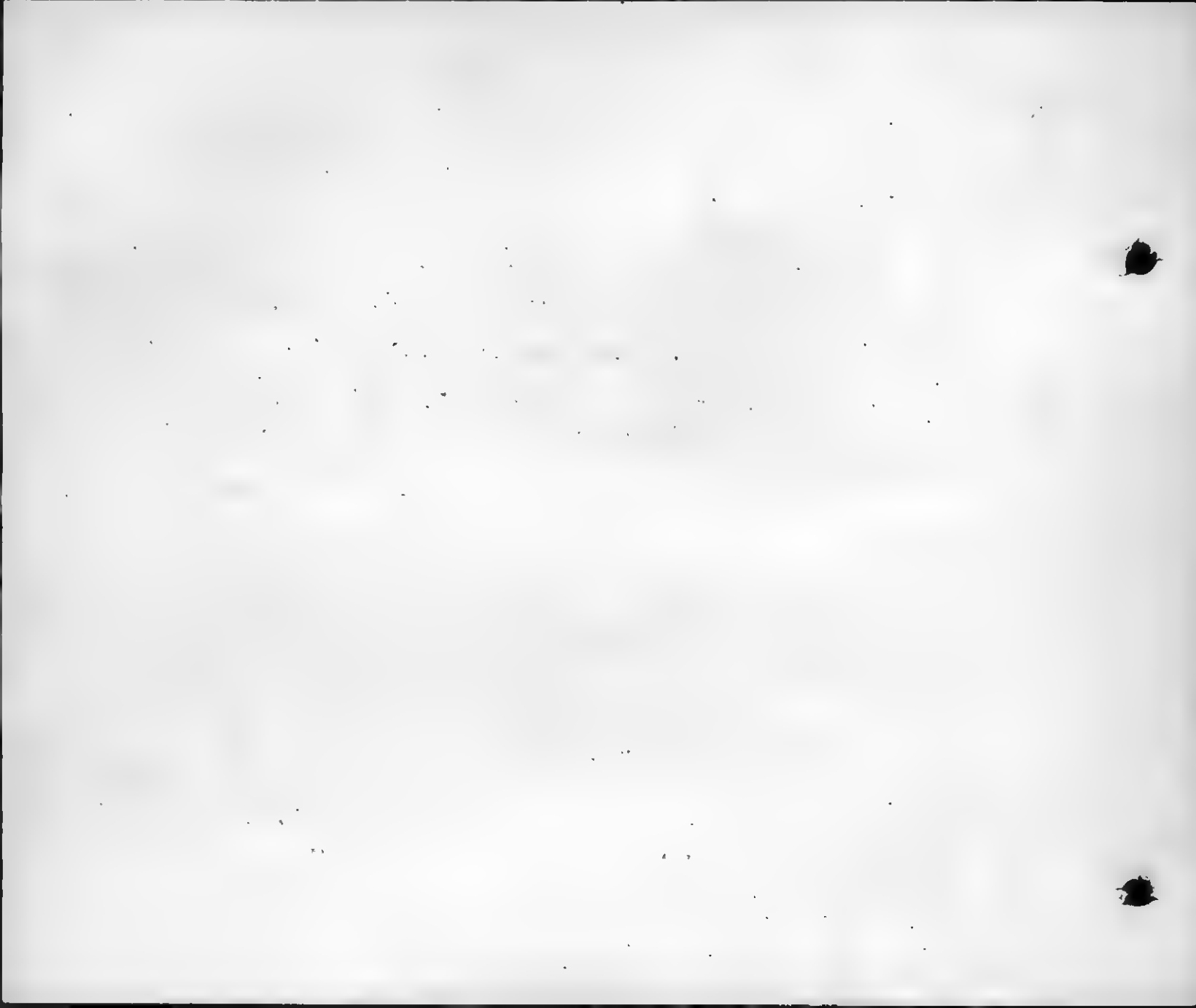
Reg. Dist. No.

06411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Big Falls Rd.</u>		d. STREET ADDRESS <u>Big Falls Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Banks</u> Middle <u>H.</u> Last <u>Berry</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>4</u> Hours <u>54</u> Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
12. BIRTHPLACE (State or foreign country) <u>Peru Lack, Pa.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Edgar Banks</u>		15. MOTHER'S MAIDEN NAME <u>Margaret Hollicamp</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>186-03-2940</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BODY OF PANCREAS</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>157X</u> DUE TO (c) <u>157X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>157X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>61</u> , to <u>June 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>61</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>HAMPSTEAD, MD</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>6-21-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fosters Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carol Hantenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>JUN 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

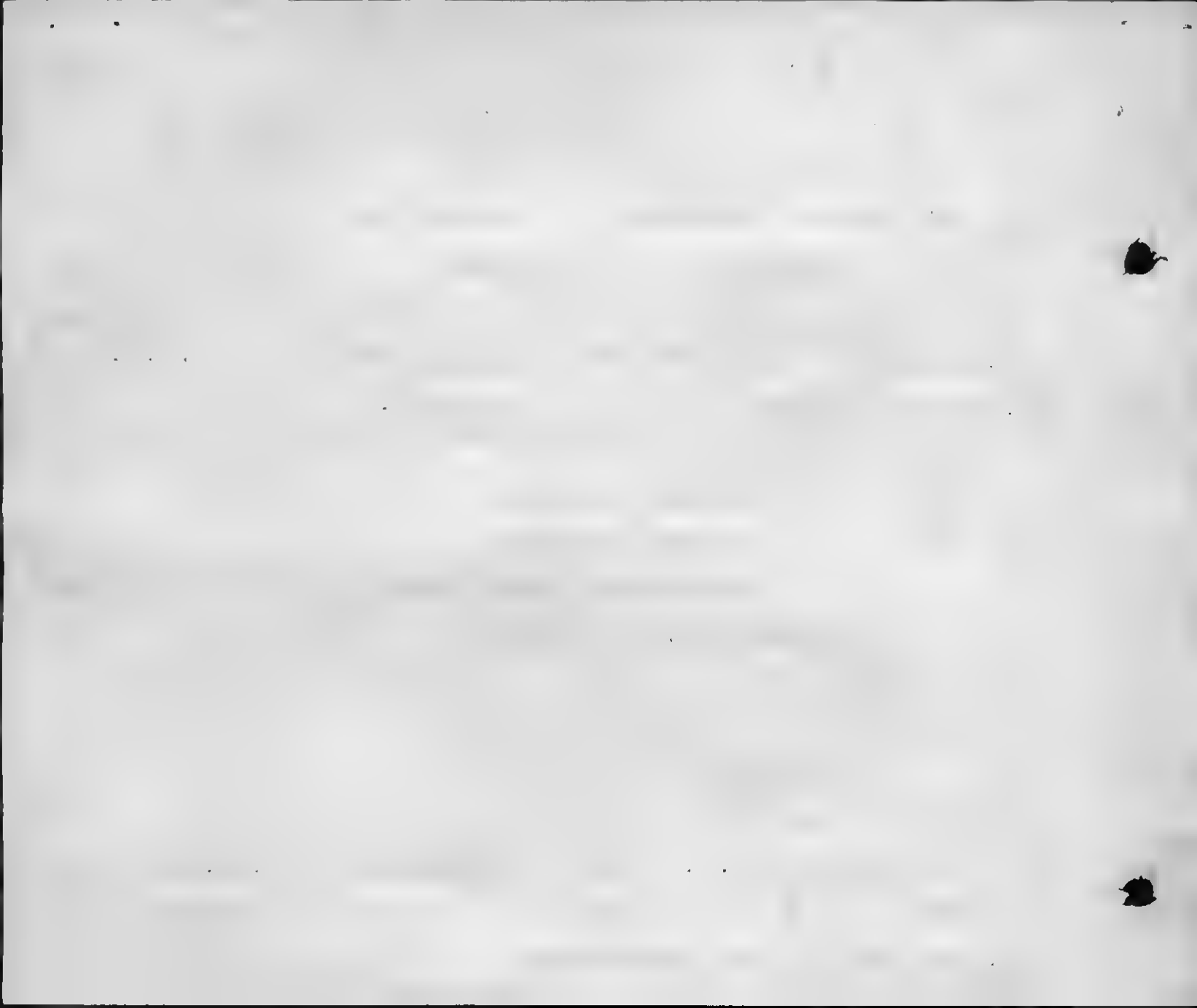
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06412

1. PLACE OF DEATH a. COUNTY V Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 5 1/2 Hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE [Where deceased lived, if institution; Residence before admission] a. COUNTY Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freedom c. STREET ADDRESS Bentley Road d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) SAMUEL BIRKMAIER		4. DATE OF DEATH Month June Day 7 Year 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 23, 1900		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman				10b. KIND OF BUSINESS OR INDUSTRY Country Club				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick J. Birkmaier				14. MOTHER'S MAIDEN NAME Mary Hueston				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 218-09-7261	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) (a) IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION (b) CORONARY THROMBOSIS (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema.- 1 Day Duration												INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 7 DAYS UNKNOWN	
18. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 61 Hour a.m. 4:PM p.m. 6/7 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore (County) (State)	
21. I certify that (this hospital) attended the deceased from 4:PM 6/7/61 to June 7, 1961 , that (s) (we) last saw the deceased alive on June 7, 1961 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.													
22a. SIGNATURE Thomas F. Crahan, M. D.										22b. DATE SIGNED 6/8/61			
22c. PHYSICIAN'S NAME (Type) Thomas F. Crahan, M. D.												22d. ADDRESS VAH, Baltimore 18, Md., Ft. Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-10-61				23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City, town or county) Baltimore, Maryland (State)	
24 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.						25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

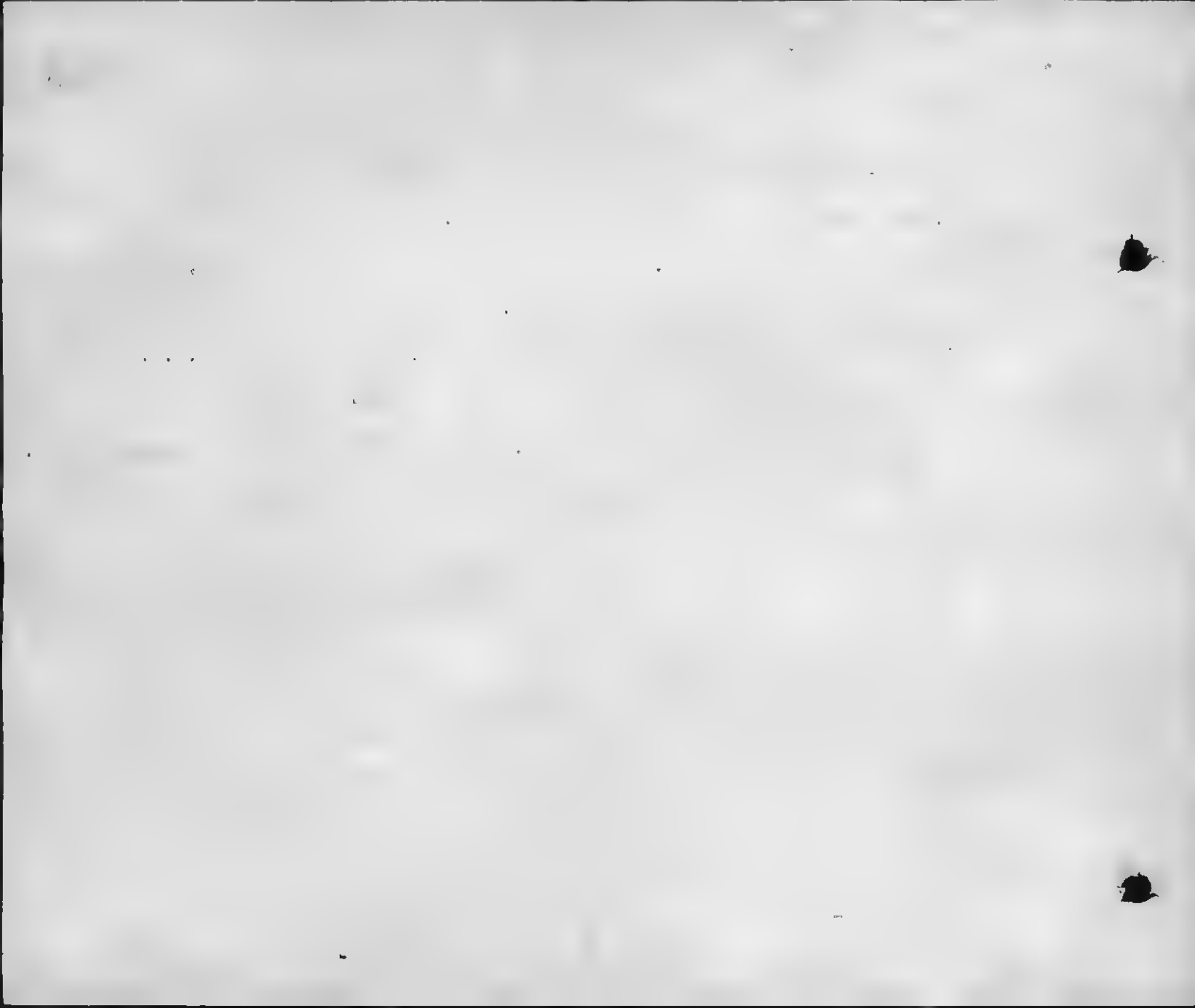
6429

06413

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Catonsville</u> c. LENGTH OF STAY IN 1b <u>Catonsville</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 S. Beechwood Road</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>9 S. Beechwood Road</u>					
3. NAME OF DECEASED (Type or print) <u>Martha C. Blackman</u>		4. DATE OF DEATH <u>June 7, 1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31, 1908</u>					
9. AGE (In years last birthday) <u>73</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles Darskadon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Bahl</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>115-021-1000</u>					
17. INFORMANT <u>Mrs. Jean Todd</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) a. EATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic hypertensive cardiovascular disease</u> b. DUE TO <u>443X</u> c. DUE TO <u>any, which gave rise to immediate cause (a), stating the underlying cause last</u>					
19. INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , 19... to <u>June 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1961</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt, Jr.</u>		22b. DATE SIGNED <u>6-8-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>		22d. ADDRESS <u>1118 St Paul St. Balto 2, Md.</u>					
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Removal 16-2-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North Anna Ave</u>					
23d. LOCATION (City, town or county) <u>Keyser, West Virginia</u>		23e. REC'D BY REGISTRAR <u>John J. Tucker, Jr.</u>					
23f. REGISTRAR'S SIGNATURE <u>John J. Tucker, Jr.</u>		23g. DATE <u>JUN 9 '61</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



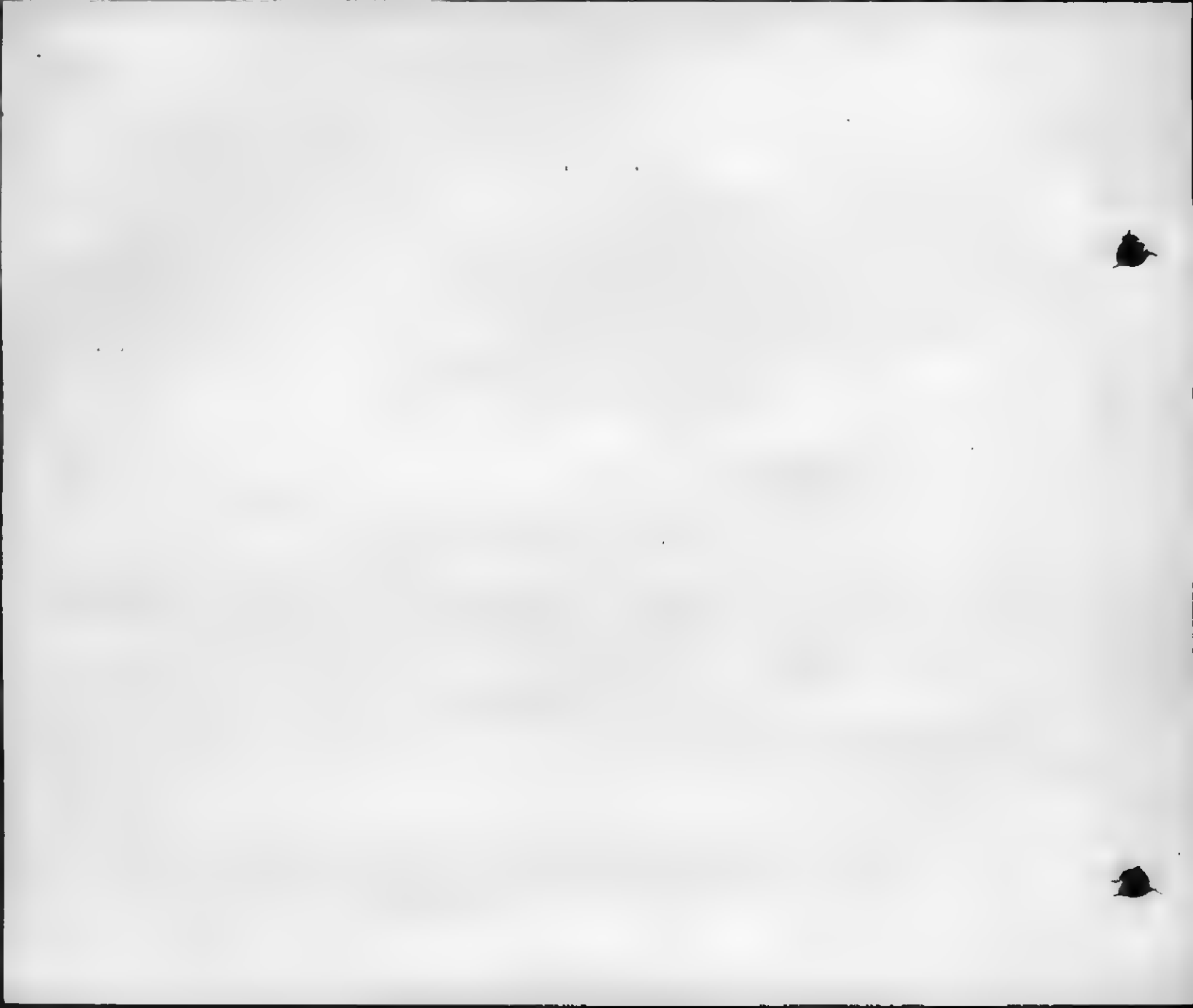
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

6430
MAY 25 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06414

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mo. 1 wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Route 3	
3. NAME OF DECEASED (Type or print) First James Middle William Last BLADEN		4. DATE OF DEATH Month June Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1878
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BLADEN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. YES.	
17. INFORMANT Records, Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH hours _____ years _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from March 8, 1961 to June 16, 1961 , that (I) (we) last saw the deceased alive on June 16, 1961 , and that death occurred on June 16, 1961 at 5:35 PM from the causes and on the date stated above.			
22a. SIGNATURE José R. Arizaga		22b. DATE SIGNED 6/14/61	
22c. PHYSICIAN'S NAME (Type) JOSÉ R. ARIZAGA, M.D.		22d. ADDRESS SPRING GROVE STATE HOSP.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF June 20, 1961	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) BLADENSBURG, MD	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.		25a. REC'D BY REGISTRAR DATE JUN 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur E. Knepper			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06415

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2910 PUTTY HILL AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>BLAKELEY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 - 1903</u>
9. AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTORS</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Blakeley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah L. —</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-5359</u>	
17. INFORMANT <u>ANNIE BLAKELEY</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>undisturbed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> to <u>6-22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-23</u> , 19 <u>61</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7.22 Hartford Rd 6.23.61</u>	
PHYSICIAN'S NAME (Type) <u>DR JOS. SKLOVEN</u>		M.D. <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 26 - 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS + Son</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>	

(M)

(I)

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06416**

6432

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1448 CHAIRIDGE RD		1 d STREET ADDRESS 1448 CHAIRIDGE RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE MAE BLANTZ		4. DATE OF DEATH Month Day Year JUNE 16, 1961	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1889 9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard H. Brady		14. MOTHER'S MAIDEN NAME EMMA V. HARWAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT MR. JOHN W. BLANTZ		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatosis 170X DUE TO Carcinoma of Rt. breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 1 year 2 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1916 to 6/16 , 19 61 , that I last saw the deceased alive on 6/16 , 19 61 , and that death occurred at 8:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eliot W. Johnson M.D.		ADDRESS (Street, city or town, state) 3432 Reservoir Ave DATE SIGNED 6/17/61	
PHYSICIAN'S NAME (Type) Baltimore 29. N.Y.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/20/1961	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem.	22d. LOCATION (City, town, or county) (State) ANNAPOLIS Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. Truman Johnson ADDRESS 3512 Fieldview Court (29)		24a. REC'D BY REGISTRAR DATE JUN 19 61 24b. REGISTRAR'S SIGNATURE C. H. S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

6433

6433

CERTIFICATE OF DEATH

06417

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 87 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home				e. STREET ADDRESS Old Frederick Rd. & Myer's Drive			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle L. Last BLUM				4. DATE OF DEATH Month June Day 25 Year 19 61			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1874		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Truck Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Blum				14. MOTHER'S MAIDEN NAME Catherine ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. John C. Gonce Sr. 205 Osborne Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & chronic Congestive Heart Failure DUE TO (b) Degenerative Heart Disease DUE TO (c) Pulmonary Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS FOUND OR GIVEN IN PART I (a) General Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18a)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 1961 to 6/25/61 , that (I) () last saw the deceased alive on 6/24/61 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. E. McGrath M. D.				22b. DATE SIGNED 6/27/61			
22c. PHYSICIAN'S NAME (Type) W. E. McGrath M. D.				22d. ADDRESS 1303 Frederick Rd. Catonsville - 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/1961		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home				25a. REC'D BY REGISTRAR DATE JUN 28 '61		25b. REGISTRAR'S SIGNATURE C. S. Thomas	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06418

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md.
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W Owings Mills
d. STREET ADDRESS 24 Lastgate Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Elizabeth
First Middle Last
4. DATE OF DEATH June 13 1961
Month Day Year

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 26, 1878
9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Joseph Brooks
14. MOTHER'S MAIDEN NAME Elizabeth ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. Mr. W. T. Brooks, 24 Lastgate Rd.
17. INFORMANT Elizabeth ? Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Broncho pneumonia
150.0 DUE TO (b) Arteriosclerosis Ge
Conditions (a) & (b) gave rise to immediate cause (a), stating the underlying cause last (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
Interval between onset and death 6 days
10 years

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 12, 1961, to May 13, 1961, that (I) (we) last saw the deceased alive on May 12, 1961, and that death occurred at 11:58 M, from the causes and on the date stated above.

22a. SIGNATURE Wm. J. Tiekner
22c. PHYSICIAN'S NAME (Type) Wetherbee Fort
22d. ADDRESS 1158 St. Paul St. Balto. Md
22b. DATE SIGNED 6/14/61
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 6/16/61
23c. NAME OF CEMETERY OR CREMATORY Loudon Park
23d. LOCATION (City, town or county) (State) Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons ADDRESS Baltimore, Md.
25a. REC'D BY REGISTRAR JUN 16 '61
25b. REGISTRAR'S SIGNATURE Charles S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06419**

6435

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		d. STREET ADDRESS 2908 Yorkway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2908 Yorkway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LeRoy Wellington Brown, Sr.				4. DATE OF DEATH Month Day Year June 29th, 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1913	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick J. Brown				14. MOTHER'S MAIDEN NAME Superior Keffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 219-01-2868		17. INFORMANT Address Emma G. Brown same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) A-S-C-V Disease (c) Stroke DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Melvin B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/30/61	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REC'D BY REGISTRAR DAIEL G '61		24b. REGISTRAR'S SIGNATURE Arthur J. K...	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 18 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMO. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

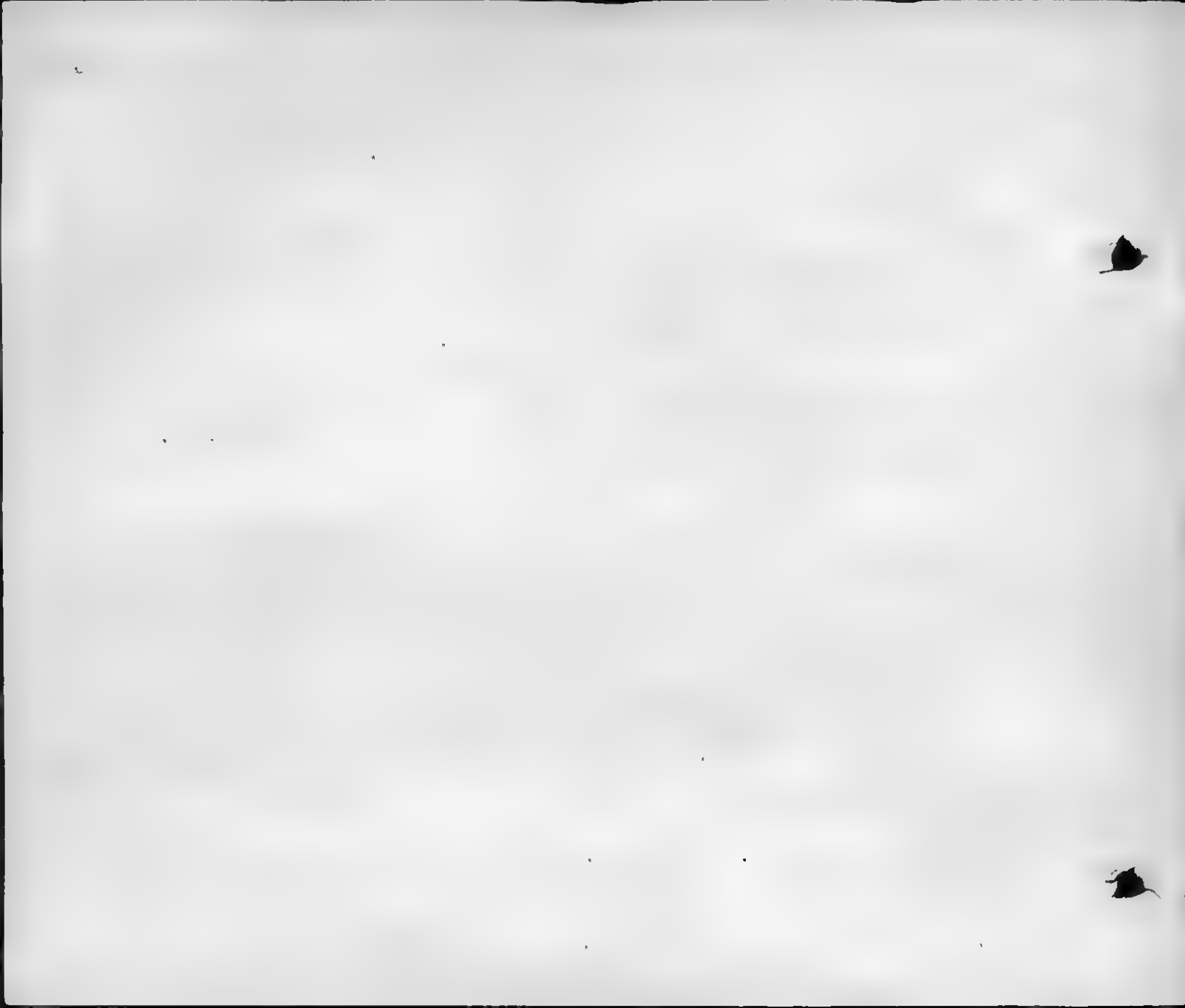
CERTIFICATE OF DEATH

Reg. Dist. No. **06420**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mabel First Butler Last		4. DATE OF DEATH June 14 Month 1961 Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/1880
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months 12 Days 14 Hours 14 Min 14	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Romulus Snyder		14. MOTHER'S MAIDEN NAME Emma Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT 75 Oella Ave, Oella, Md.		18. INTERVAL BETWEEN ONSET AND DEATH 10 YRS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 YRS (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-29 19 58 to 6-14 19 61 , that I last saw the deceased alive on 6-12 19 61 , and that death occurred at 7:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 40 Columbia Road Ellicott City, Maryland DATE SIGNED June 15, 1961			
ACTUAL SIGNATURE P. H. Thorne		PHYSICIAN'S NAME (Type) Doctor Van P. Thorne, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/19/61	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE F.C. HIGLEBOTHOM ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE JUN 19 1961	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

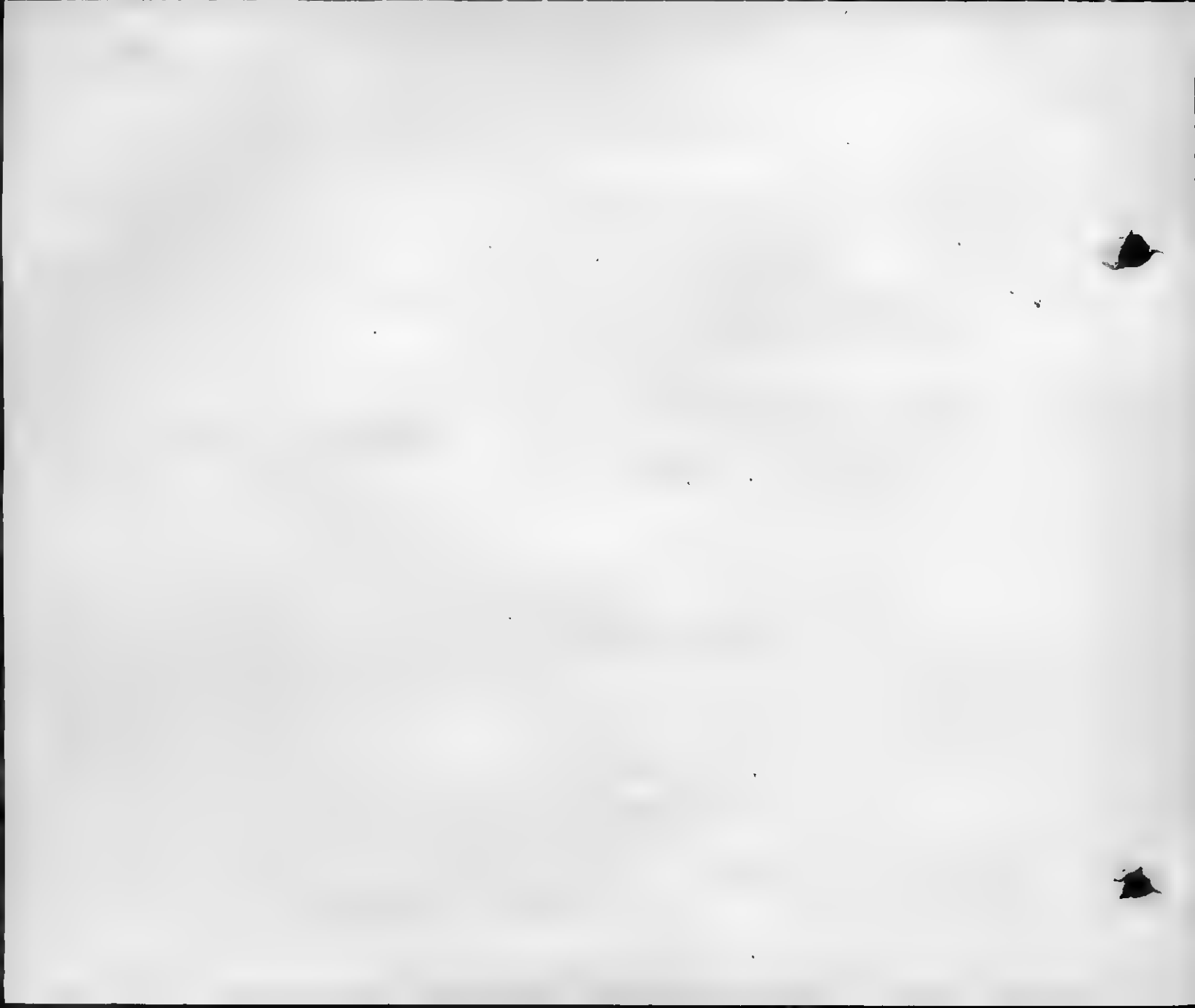
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



06421

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Piedway Manor Nursing Home</u>				d. STREET ADDRESS <u>4149 Mountwood Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Agnes</u>	Middle <u>V.</u>	Last <u>Callahan</u>	4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1961</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1874</u>		9. AGE (In years last birthday) <u>86</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Mock</u>				14. MOTHER'S MAIDEN NAME <u>Sarah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Geo. T. Callahan, 4149 Mountwood Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cipopley</u> <u>334</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cerebro</u> DUE TO <u>Vascular Decort</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<u>Seizure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1961</u> to <u>June 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1961</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>M. Paul Byrd</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. Paul Byrd</u>				22d. ADDRESS <u>3033W North A. Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter T. N. 4101 Edmondson Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

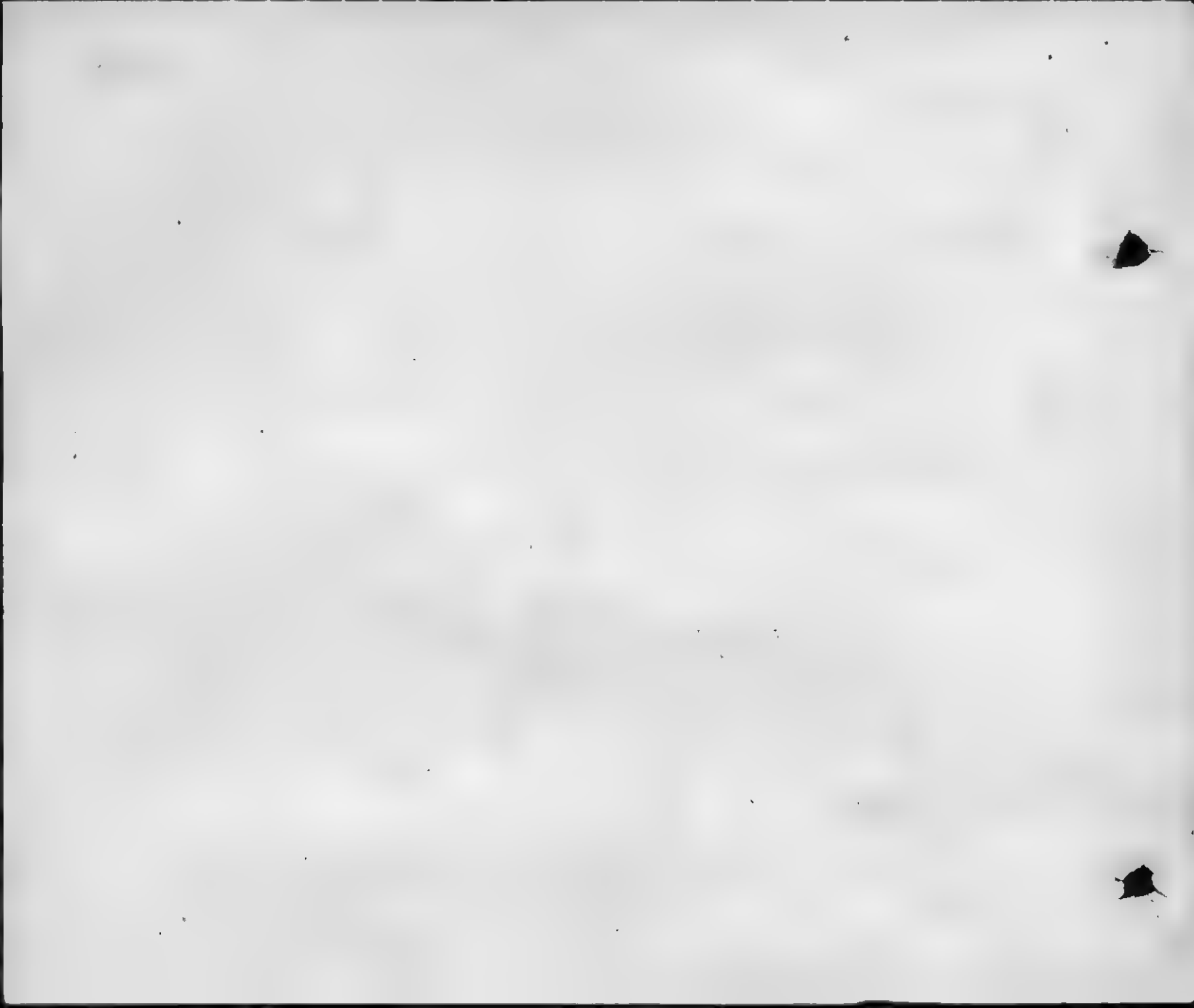


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MEDICAL CERTIFICATION OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

6438
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06422

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FREDERICK + HILLSIDE RD.</u>		d. STREET ADDRESS <u>Frederick and Hillside Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM S. CAMPBELL</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>electrical</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>---</u>	
13. FATHER'S NAME <u>James Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Digney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-01-7477</u>	
17. INFORMANT <u>Mrs William Campbell</u>		18. ADDRESS <u>Frederick + Hillside Rds, Catonsville, Md.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Carcinoma Lung Rt. Metastases to Liver.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Drephrogastic Hernia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>Md. Baltimore, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/2/61</u> to <u>6/5/61</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>6/2/61</u> , and that death occurred <u>6/5/61</u> from the causes and on the date stated above.		22a. SIGNATURE <u>W. E. McGroth</u>	
22b. PHYSICIAN'S NAME (Type) <u>W. E. McGroth</u>		22c. ADDRESS <u>1303 Frederick Rd Catonsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>6/6/61</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>New Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Haganbottom</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. DATE <u>6/5/61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6433

06423

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor-5743 Edmondson Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5456 Frederick Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace</u> <u>Serio</u> <u>Cascio</u>		4. DATE OF DEATH Month Day Year <u>June 1, 1961</u> <u>19</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 3, 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Joseph Serio</u>		14. MOTHER'S MAIDEN NAME <u>Concetta Giglio</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Vincent Cascio-6123 Northdale Road</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>THROMBOSIS</u> (b) <u>CEREBRAL</u> (c) <u>2X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hypertensive CV Disease. Diabetes Mellitus.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-3-57</u>, 19<u>57</u>, to <u>June 1</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>May 31</u>, 19<u>61</u>, and that death occurred at <u>10:15</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John F. Schaefer</u>		22b. DATE SIGNED <u>June 2 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John F. Schaefer</u>		22d. ADDRESS <u>1401 Random Road</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-5-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Hume</u>		25a. REC'D BY REGISTRAR <u>June 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Hume</u>	

MEDICAL CERTIFICATION

The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06440

06424

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 104 E. Susquehanna Avenue		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 104 E. Susquehanna Avenue	
3. NAME OF DECEASED (Type or print) ETHEL ELIZABETH CASLIN Middle 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 21, 1911 9. AGE (in years last birthday) 49 yrs. 10. KIND OF BUSINESS OR INDUSTRY Housewife 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Clayton Lawson 14. MOTHER'S MAIDEN NAME Bessie Gouldman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-10-3351 17. INFORMANT Family Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of lung with metastases DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 2, 1961, to June 28, 1961, that (I) (we) last saw the deceased alive on June 28, 1961, and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) L. Myrton Gaines, Jr.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 714 York Road, Towson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28, 1961	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens		23d. LOCATION (City, town or county) Timonium, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR DATE JUN 3 '61 25b. REGISTRAR'S SIGNATURE	

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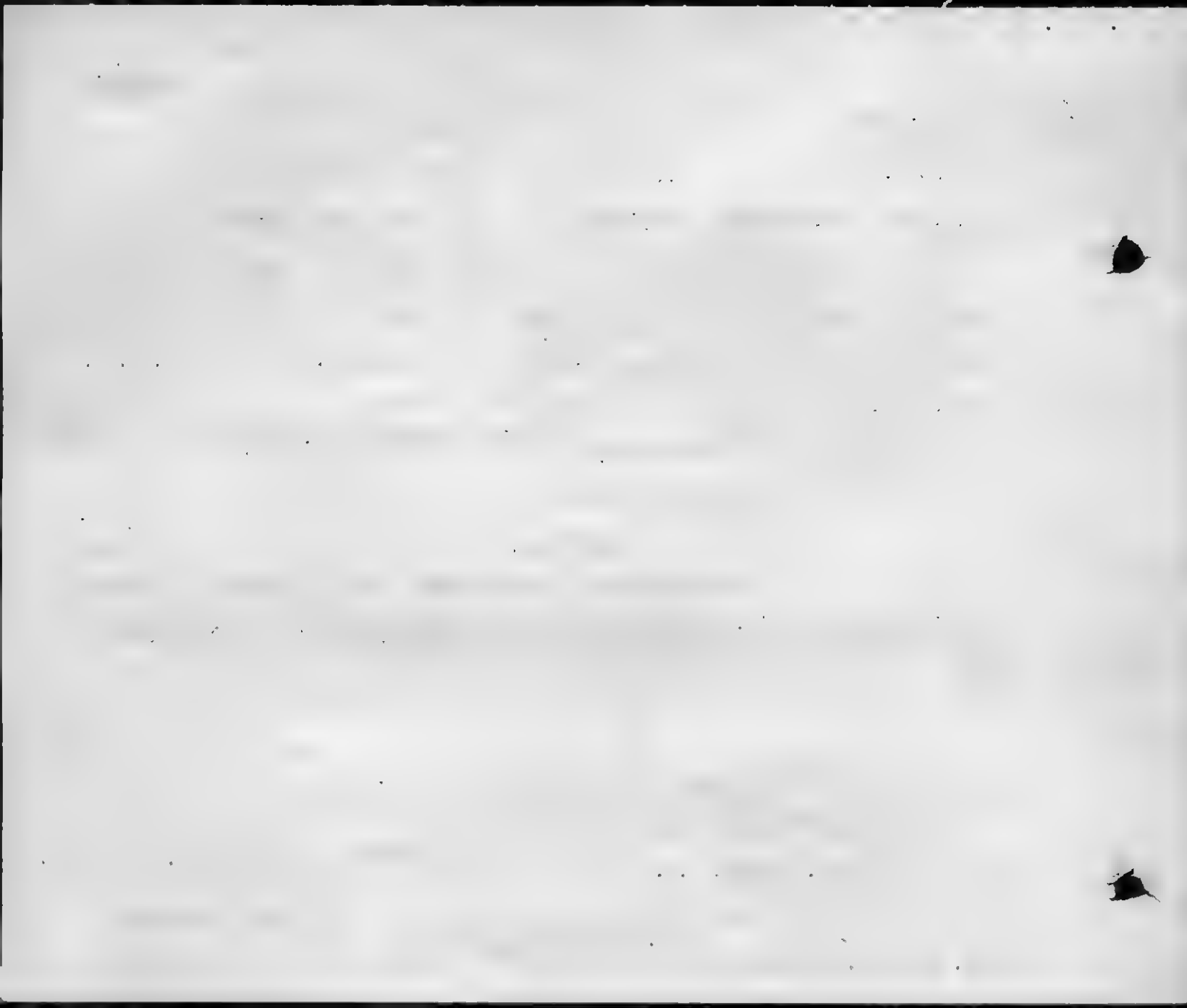
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6441 CERTIFICATE OF DEATH 06425

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN IS <u>33 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(23)</u> d. STREET ADDRESS <u>204 North Amity Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>----</u> Last <u>CHASE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Gas & Electric Co.</u>	
13. FATHER'S NAME <u>Walter Chase</u>		14. BIRTHPLACE (County & State or foreign country) <u>Anne Arundel Co., Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>212-05-3245</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>PERITONITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to SIGMOID PERFORATION</u> <u>XXXXX</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE WITH FIBRILLATION</u>		18. BIRTHPLACE (County & State or foreign country) <u>U. S. A.</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sigmoid Diverticulosis. Operations: 5/22/61, Incision & Biopsy, Myositis (ostomy), 7/61, Closure, ruptured sigmoid-repair, incarcerated hernia. Closure, Tracheo-</u>		20. INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u> <u>11 Days</u> <u>11 Days</u> <u>Unknown</u>	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 18, 1961</u> to <u>June 20, 1961</u> , that <u>he</u> (we) last saw the deceased alive on <u>June 20, 1961</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.			
28. SIGNATURE <u>Thomas F. Crahan</u> M.D.		29. DATE SIGNED <u>6/20/61</u>	
30. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>		31. ADDRESS <u>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE THEREOF <u>6/23/61</u>	
34. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		35. LOCATION (City, town or county) (State) <u>Baltimore 28, Maryland</u>	
36. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>		37. ADDRESS <u>322 N. Schroeder Street</u>	
38. REC'D BY REGISTRAR <u>DATE JUN 22 '61</u>		39. REGISTRAR'S SIGNATURE <u>C. L. G. Hume</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

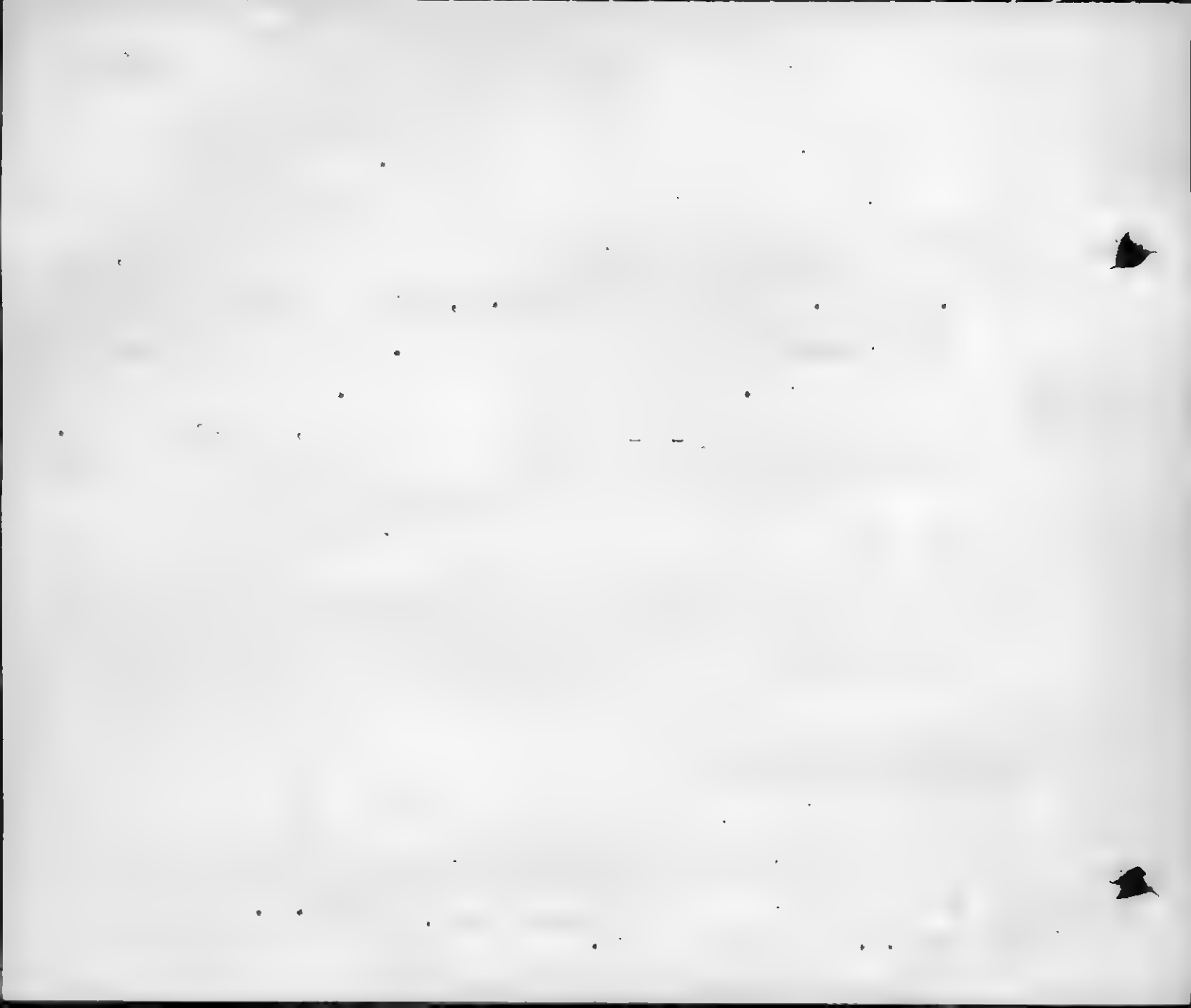
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06426

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines		d. STREET ADDRESS 2342 Edmondson Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Caroline Claus		4. DATE OF DEATH Month Day Year June 23, 1961	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Claus		14. MOTHER'S MAIDEN NAME Kathie M. Reese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-03-2471	
17. INFORMANT Address Mrs Robert Ernest, 6101 Brookwood Rd. #29			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive - Cardiovascular disease DUE TO (c) 5 yrs			INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1945 to June 23, 1961 , that (I) (we) last saw the deceased alive on June 22, 1961 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Homer U. Todd		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Homer U. Todd		22d. ADDRESS 2108 St Paul St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/26/61	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cmty.	23d. LOCATION (City, town, or county) (State) Balto. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		25. REC'D BY REGISTRAR JUN 26 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Knead	



6443

06427

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence after admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Cinder Road		d. STREET ADDRESS 16 Cinder Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Elizabeth Last Coffman		4. DATE OF DEATH Month 6-1- Day 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1904
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min. 1	11. IF UNDER 24 HRS Months 5 Days 1 Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler		10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp. Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Franklin		14. MOTHER'S MAIDEN NAME Ocie Maupin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-9386	
17. INFORMANT Husband		18. ADDRESS 16 Cinder Road Timonium Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL CARCINOMATOSIS - HEPATIC - COLON CA - DUE TO (b) 5 MOS. DUE TO (c) 5 YR.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from 2-17-61 to 6-1-61 , that (2) we last saw the deceased alive on 5-31-1961 and that death occurred 8:00 AM from the causes and on the date stated above.			
22a. SIGNATURE Donald O. Wood, M.D.		22b. DATE SIGNED 6/2/61	
22c. PHYSICIAN'S NAME (Type) DONALD O. WOOD, M.D.		22d. ADDRESS YORK RD 2 GREEN MEADOW 213 - TIMONIUM	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-61	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City, town, or county) (State) Finksburg Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md.		25a. REC'D BY REGISTRAR JUN 6 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06428											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oella, Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>519 Oella Ave</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u></u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>45 Tenney St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry J Collins</u>						4. DATE OF DEATH Month Day Year <u>June 15, 1961</u>			9. AGE (In years, last birthday) <u>78</u> Yrs. Months Days		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-27-1882</u>		10. AGE UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Collins</u>						14. MOTHER'S MAIDEN NAME <u>Flaherty</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>21-61-547</u>					
17. INFORMANT <u>Michael Collins</u>						Address <u>519 Oella Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Ger M. Kieffer</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Ger M. Kieffer</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>June 15, 1961</u>					
Address (Street, city, town, or county) <u>2010 I St Ave</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore Md</u>					
23. FUNERAL DIRECTOR <u>Max Habb & Son - Catonsville - 78-Md</u>						ADDRESS <u></u>		24a. REC'D BY REG. STRAR <u></u>		24b. REG. STRAR'S SIGNATURE <u>Arthur S. Hanes</u>	
DATE <u>JUN 20 '61</u>											



CERTIFICATE OF DEATH

Reg. Dist. No. 06429

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>21</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8604 SUMMIT Ave</u>		d. STREET ADDRESS <u>8604 SUMMIT Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PATRIC K</u> First <u>J</u> Middle <u>D</u> Last <u>COOK</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21 - 1961</u>
9. AGE (In years lost birthday) yrs <u>2</u> Months <u>19</u> Days <u>19</u> Hours <u></u> Min <u></u>		10. IF UNDER 1 YEAR <u>2</u> Months <u>19</u> Days <u>19</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER J COOK</u>		14. MOTHER'S MAIDEN NAME <u>JO ANN MYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>PETER J. COOK</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO		Pneumonitis Bronchiolitis Interval BETWEEN ONSET AND DEATH <u>6 hr.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> At work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/5</u> , 19 <u>61</u> , to <u>6/10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/5</u> , 19 <u>61</u> , and that death occurred at <u>8:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 HARFORD Rd</u> DATE SIGNED <u>6/10/61</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/12/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & SON</u> ADDRESS <u>8802 HARFORD Rd</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06430

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7520 SCHOOL AVE.</u>				d. STREET ADDRESS <u>7520 SCHOOL AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BERT</u> Middle <u>CRATER</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-75</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PERCIVAL CRATER</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HONTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>170-05-598</u>		17. INFORMANT Address <u>HARRY CRATER, 7520 SCHOOL AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC C.V. DIS.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1961</u> to <u>June 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 21, 1961</u> , and that death occurred at <u>12:55 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stephen C. Mackowian</u>				22b. DATE SIGNED <u>6-23-61</u>		22c. PHYSICIAN'S NAME (Type) <u>STEPHEN C. MACKOWIAN</u>	
22d. ADDRESS <u>6714 Hololand Ave Baltimore 22 Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>REMOVAL/BURIAL</u>				<u>GETHSEMANE CEM.</u>		<u>READING, PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME, DUNDALK, MD.</u>				25a. REC'D BY REGISTRAR <u>DATE JUN 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

I



CERTIFICATE OF DEATH

06431

1. PLACE OF DEATH
 a. COUNTY Baltimore MARYLAND
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium
 c. LENGTH OF STAY in lb
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2303 Ravenview Road

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
 a. STATE Maryland b. COUNTY Baltimore
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium
 d. STREET ADDRESS 2303 Ravenview Road
 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Grace M. Crowther
 First Middle Last
 4. DATE OF DEATH June 1, 1961
 Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Dec. 5, 1886
 Widowed ☒ Divorced ☐ 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Mackey 14. MOTHER'S MAIDEN NAME Martha ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Mr. C. M. Cummings-2303 Ravenview Road Address

18. CAUSE OF DEATH [Enter only one cause per line for a), (b), and (c)]
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO
 170X Carcinoma Rt. Breast (b)
 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Diabetes Mellitus DUE TO
 PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
 20d. INJURY OCCURRED While at work ☐ Not While at work ☐
 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
 20f. (City or town) (County) (State)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

21. I certify that (I) (this hospital) attended the deceased from 6-22-1961 to 6-1-1961, that (I) (we) last saw the deceased alive on 6-1-1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

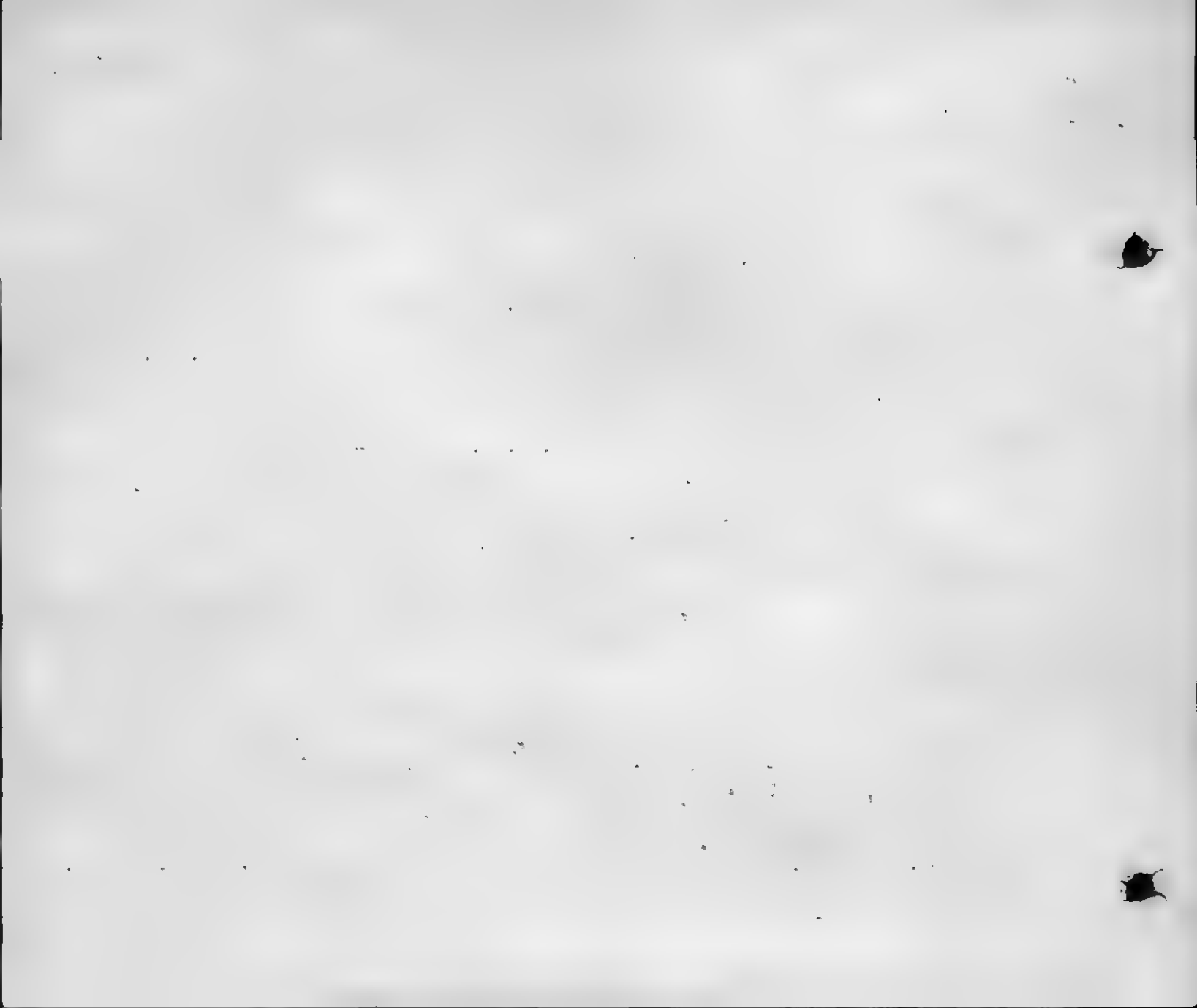
22a. SIGNATURE Robert H. Silver M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 6-2-61
 22c. PHYSICIAN'S NAME (Type) Dr. Robert H. Silver 22d. ADDRESS 3105 North Charles St. Balto. 18, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6-3-61 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery 23d. LOCATION (City, town or county) (State) Woodlawn, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Thorne 25a. REC'D BY REGISTRAR DATE JUN 2 '61 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

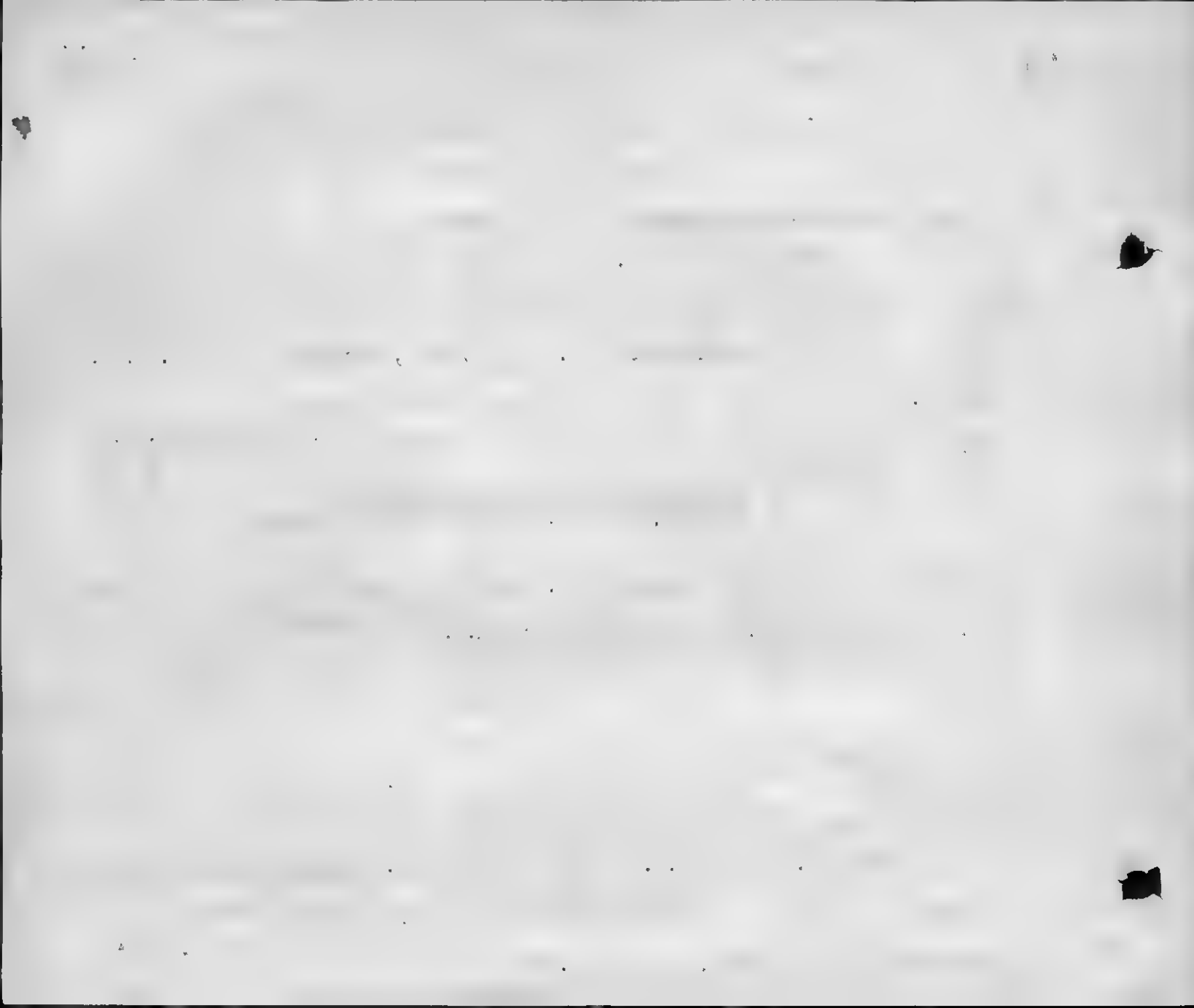
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6443

06432

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 22 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks d. STREET ADDRESS Route 1, Box 30 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEVI Thomas CURTIS		4. DATE OF DEATH June 18 1961	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/1/94 9. AGE (In years last birthday) 66 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard 10b. KIND OF BUSINESS OR INDUSTRY Machine Tool Co. 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howard T. Curtis 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I 16. SOCIAL SECURITY NO. 216-07-5701 17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		18. CAUSE OF DEATH [Enter only one cause per line for a, (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) HEMORRHAGE, RETROPERITONEAL MASSIVE RUPTURE, (RECENT), ABDOMINAL AORTIC ANEURYSM CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STEREO THE UNDERLYING CAUSE LAST. (b) ARTERIOSCLEROSIS, MARKED, GENERALIZED marked, bilateral. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 1. Portal Cirrhosis, liver, duration-unknown. 2. Pulmonary Emphysema, / 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from May 27 1961, to June 18 1961 that (2) (we) last saw the deceased alive on June 18 1961, and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Crahan</i> 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTO. 18, MD, FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6-21-61		23c. NAME OF CEMETERY OR CREMATORY Falls Road Methodist Church Cemetery 23d. LOCATION (City, town or county) (State) Sparks, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE XXXXX Brooks Funeral Home, 622 York Rd. Towson 4, Maryland		25a. REC'D BY REGISTRAR DATE JUN 20 '61 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



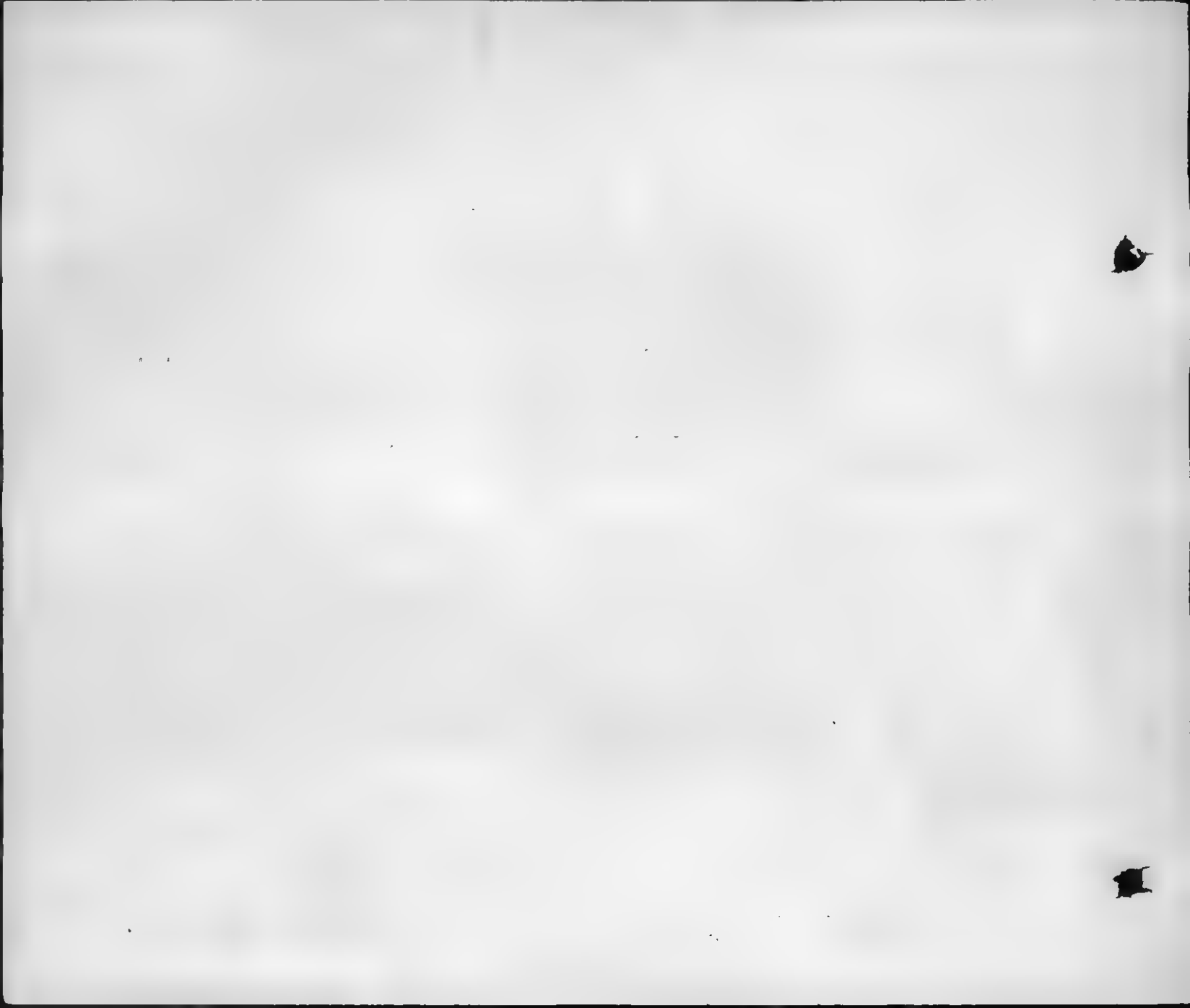
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06433

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 and 5 be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bear Creek (Towerness)		c. LENGTH OF STAY IN 1b 1 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wise Avenue, Bear Creek Bridge		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk	
3. NAME OF DECEASED (Type or print) First MIDDLE Last JOHN FRANKLIN DAVIS		4. DATE OF DEATH Month JUNE Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 FEB 1939
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brickman		10b. KIND OF BUSINESS OR INDUSTRY Pottery, Br Dry	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Davis		14. MOTHER'S MAIDEN NAME Dorothy Hood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 219-26-2799	
17. INFORMANT Mrs. Jamie R. Davis		Address # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fall into Bear Creek	
20c. TIME OF INJURY Month, Day, Year Hour min. 6/28 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wise Ave	20f. City or town (County) (State) Dundalk - in Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE MJD Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin P. Davis		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-1961	22c. NAME OF CEMETERY OR CREMATORY Loudon Park
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. LOCATION (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		24a. REC'D BY REGISTRAR DATE JUN 26 '61	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06434

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point			c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1017 H Street				d. STREET ADDRESS 1017 H Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last DENNIS				4. DATE OF DEATH Month June Day 16th Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1874	
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Dennis				14. MOTHER'S MAIDEN NAME Mary Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 213-07-9580		17. INFORMANT Mrs. John Stitz		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis & Aortic Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 12 yrs 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1961 , to June 16, 1961 , that I last saw the deceased alive on June 16, 1961 , and that death occurred at 5:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 520 D Street DATE SIGNED 6/16/61							
ACTUAL SIGNATURE James T. Means M.D.				PHYSICIAN'S NAME (Type) James T. Means, M.D. Sparrows Point 19, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/61		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc. ADDRESS Dundalk 22, Md				24a. REC'D BY REGISTRAR DATE JUN 21 '61		24b. REGISTRAR'S SIGNATURE William S. Means	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06435											
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>605 CRPINGTON RD.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>605 CRPINGTON RD.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>605 CRPINGTON RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JOHN A. DEPPISCH</u>						4. DATE OF DEATH <u>6/4/61</u> Month <u>6</u> Day <u>4</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/6/17</u> Month <u>4</u> Day <u>6</u> Year <u>1917</u>		9. AGE (In years, last birthday) <u>44</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>JOHN A. DEPPISCH</u>						14. MOTHER'S MAIDEN NAME <u>MARTHA DENN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>08-11-1111</u>					
17. INFORMANT <u>Mrs. Margaret Deppisch</u> Address <u>1 Mallow Hill Ave., Baltimore 29, Md.</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u>5 yrs.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) <u>Leo J. Gaver</u> attended the deceased from <u>June 1947</u> to <u>June 1961</u> , that (I) <u>yes</u> last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>5:30 P.M.</u> the causes and on the date stated above.											
22a. SIGNATURE <u>Leo J. Gaver, M.D.</u>											
22b. DATE SIGNED <u>6/5/61</u>											
22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>											
22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>											
23b. DATE THEREOF <u>6/7/61</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>											
23d. LOCATION (City, town or county) (State) <u>BALTO. CO. MD.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Thomas</u>											
24b. ADDRESS <u>28</u>											
25a. REC'D BY REGISTRAR <u>JUN 7 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>											



6452

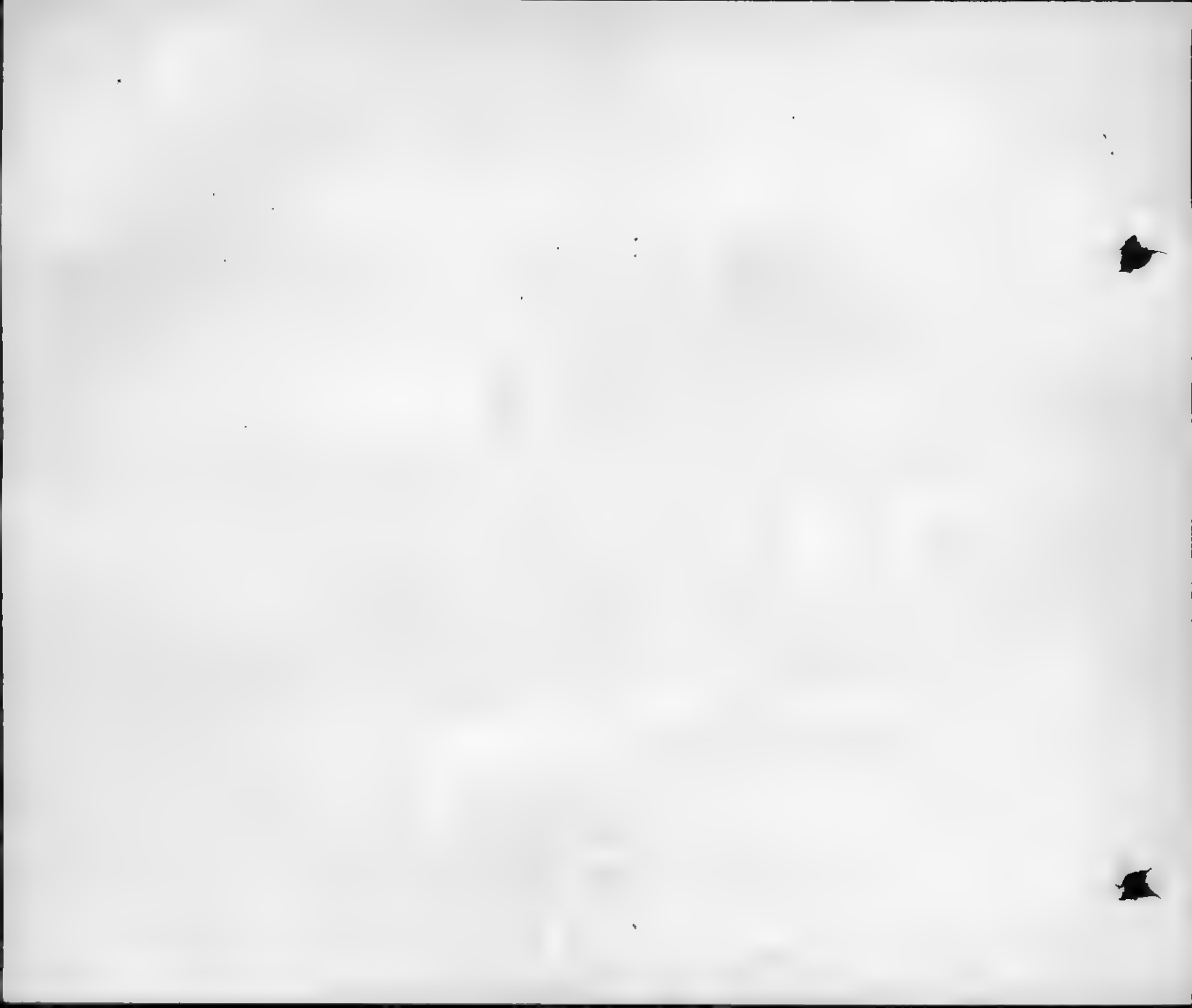
STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06436

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1709 GLEN CURTIS RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK H. DIEFENBACH		4. DATE OF DEATH JUNE 1, 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4, 1904
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY B&O RAILROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN A. DIEFENBACH		14. MOTHER'S MAIDEN NAME MINNIE KREUZLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. George Voelkel, 1709 Glen Curtis Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal shut down (c) Metastatic carcinoma		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 2 days 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/30 1961 to 6/1 1961 , that (I) (we) last saw the deceased alive on 5/30 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.			
22a. SIGNATURE J. Platt		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. PLATT, M.D.		22d. ADDRESS 4348 Eastern Ave East. md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/5/61	
23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION (City, town, or county) (State) BALTO., MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Hartley Miller, 2334 Jefferson St.		25a. REC'D BY REGISTRAR JUN 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

(M)



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

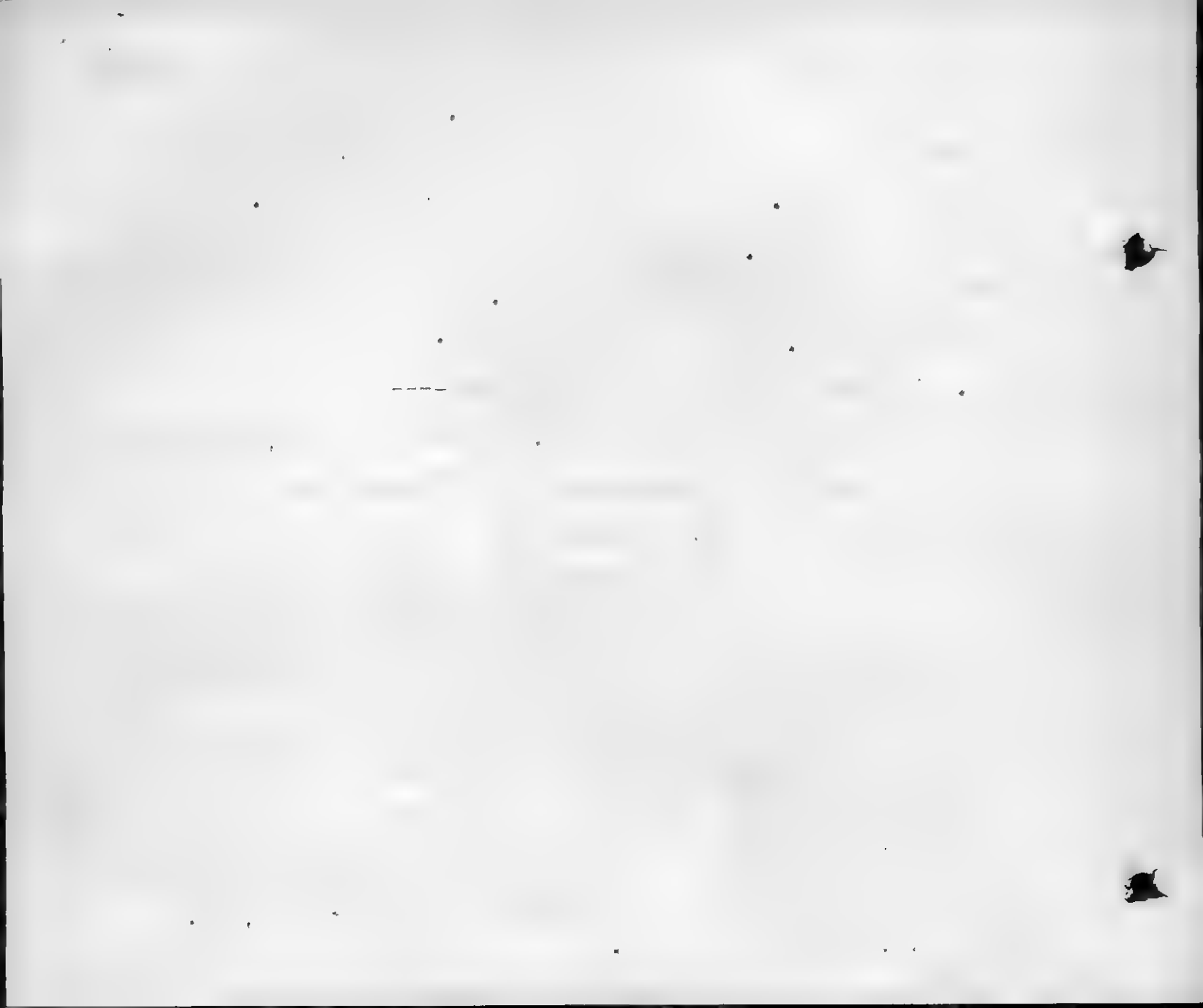
CERTIFICATE OF DEATH

6453

06437

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 650 Orpington Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martin H. Middle Dietrich Last 				4. DATE OF DEATH Month June Day 30 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10/92		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Novak Realty Co.			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Geo. Dietrich				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Margaret Dietrich, 650 Orpington Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema 153.8 DUE TO Carcinoma of Colon Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/28 19 60 to 6/30 19 61 , that (I) last saw the deceased alive on 6/30 19 61 , and that death occurred on 6/30 19 61 , from the causes and on the date stated above							
22a. SIGNATURE James Nolan				22b. DATE SIGNED 7/1/61		22c. PHYSICIAN'S NAME (Type) J. MALLON	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 3/61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. GENERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR DATE JUL 3 '61		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.



0654

CERTIFICATE OF DEATH

Reg. Dist. No. 06438

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chattolance</u>		c. LENGTH OF STAY IN 1b <u>Chattolance</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Seymour</u> Last <u>Diggs</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doorman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boering, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Eli Diggs</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Derrieks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT: Mrs. Virginia White Livingstone, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate with metastases</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>10 years</u> (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 <u>55</u> , to _____, 19 <u>61</u> , that I last saw the deceased alive on _____, 19 <u>61</u> , and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H Royse</u>		ADDRESS (Street, city or town, state) <u>1403 Foley Lane, Pikesville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>		DATE SIGNED <u>June 10, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/21/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. King</u>		ADDRESS <u>2222 W. North Ave., Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Frank</u>	



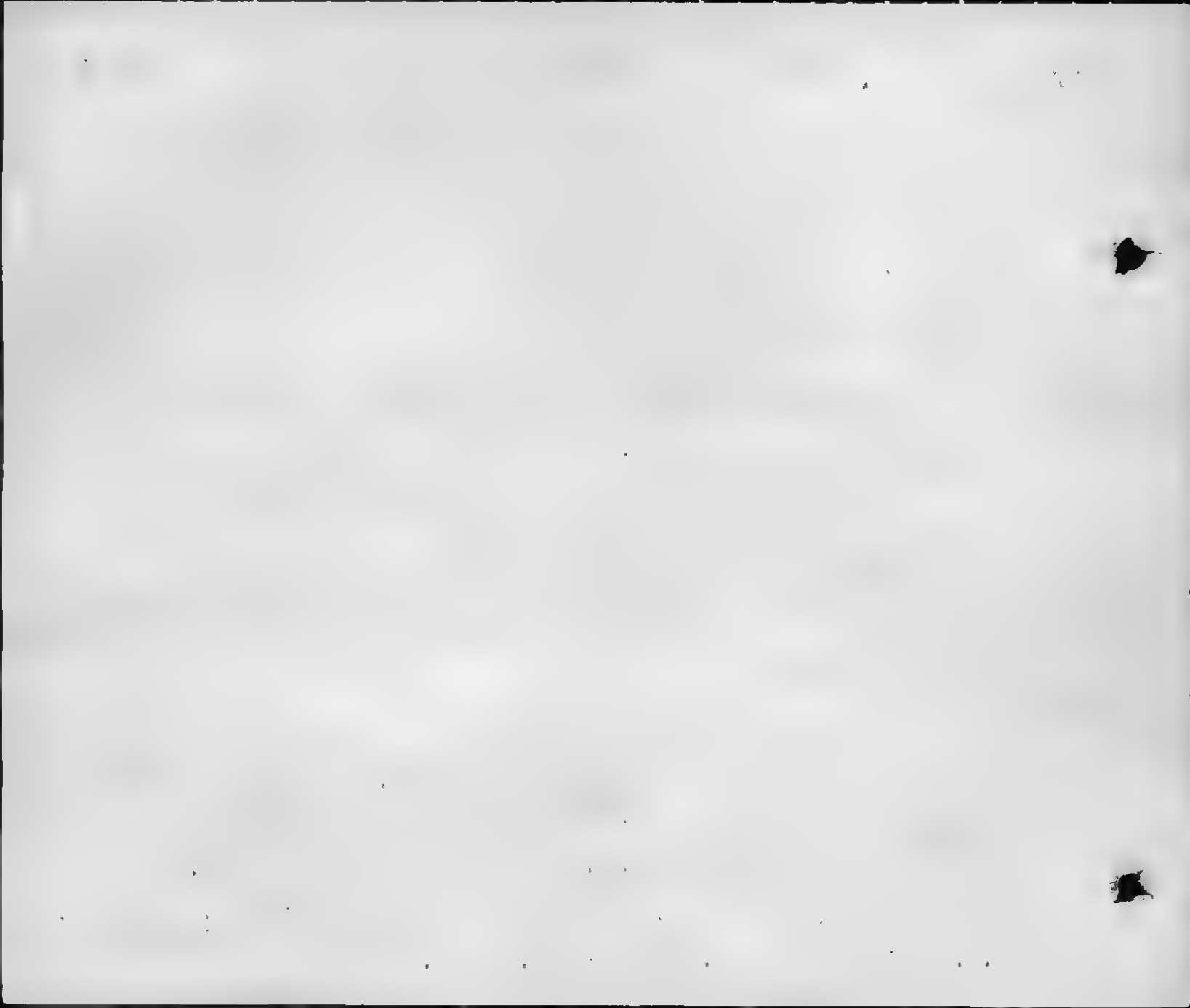
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

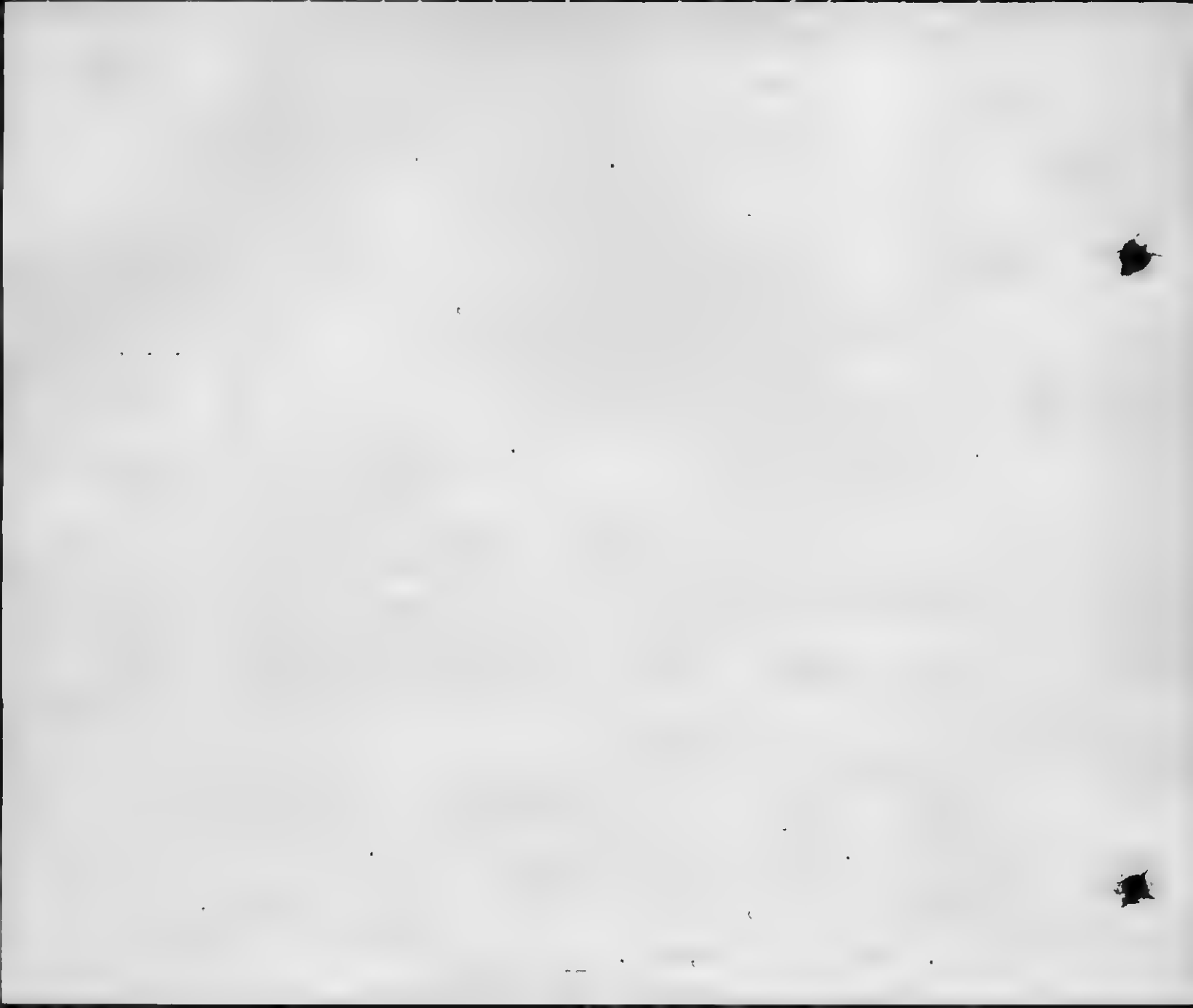
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06455									
06439									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>					c. LENGTH OF STAY IN IL <u>2mth ldy</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
f. STREET ADDRESS <u>24 Whitfield Road</u>					g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>L. Alan</u>					4. DATE OF DEATH <u>June 21</u> <u>19 61</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Aug. 8, 1885</u>				
9. AGE (In years last birthday) <u>75</u> yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.					12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>banker</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				
13. FATHER'S NAME <u>Unknown Lewis Dill</u>					14. MOTHER'S MAIDEN NAME <u>Unknown Margaret Repp</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>					16. SOCIAL SECURITY NO. <u>215-01-9109</u>				
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis, severe</u> (c) DUE TO cause last. PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1961</u> to <u>June 21, 1961</u> that (I) (we) last saw the deceased alive on <u>June 21, 1961</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Stella Wachser</u> M.D.					22b. DATE SIGNED <u>6-21-61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachser, M. D.</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>6-23-61</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>					23d. LOCATION (City, town or county) <u>Pikesville</u> (State) <u>Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>					25a. REC'D BY REGISTRAR <u>June 26 '61</u>				
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06440											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN lb 5 mo.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 404 Far Hills Court				d. STREET ADDRESS 404 Far Hills Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harriet Boynton Dodson				4. DATE OF DEATH June 11 19 61							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1875		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Home				10b. KIND OF BUSINESS OR INDUSTRY New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Boynton				14. MOTHER'S MAIDEN NAME Harriet Purmort							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Mrs. Norman Raymond				17. INFORMANT Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> DUE TO <i>Arteriosclerosis, generalized</i> (b) <i>congestive heart failure</i> DUE TO <i>Hypertension</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										INTERVAL BETWEEN ONSET AND DEATH Two weeks.	
21. I certify that (I) (this hospital) attended the deceased from 1950, 19 to June, 1961, that (I) (we) last saw the deceased alive on June 7, 1961, and that death occurred at 4:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Dr. Louis Hamburger				22b. DATE SIGNED June 12 1961							
22c. PHYSICIAN'S NAME (Type) Dr. Louis Hamburger				22d. ADDRESS 1001 St. Paul Street							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town or county) (State) Baltimore, Maryland					
24 FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place				25a. REC'D BY REGISTRAR DATE JUN 14 '61				25b. REGISTRAR'S SIGNATURE Charles S. Hand			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/80

2457
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06441

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Oxonhill, Maryland	
c. LENGTH OF STAY N 1b 2 days		d. STREET ADDRESS 4406 Brockton Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sue		4. DATE OF DEATH Month June Day 21 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1875
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT RECORDS: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying test. 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19, 1961 to June 21, 1961 , that (I) (we) last saw the deceased alive on June 21, 1961 , and that death occurred at 9:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6-22-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22b. DATE SIGNED 6-22-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6-24-61		23b. DATE THEREOF 6-24-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cmt.		23d. LOCATION (City, town or county) (State) Switzland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Turner Home Wash. D.C.		25a. REC'D BY REGISTRAR JUN 26 '61	
ADDRESS Wash. D.C.		25b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

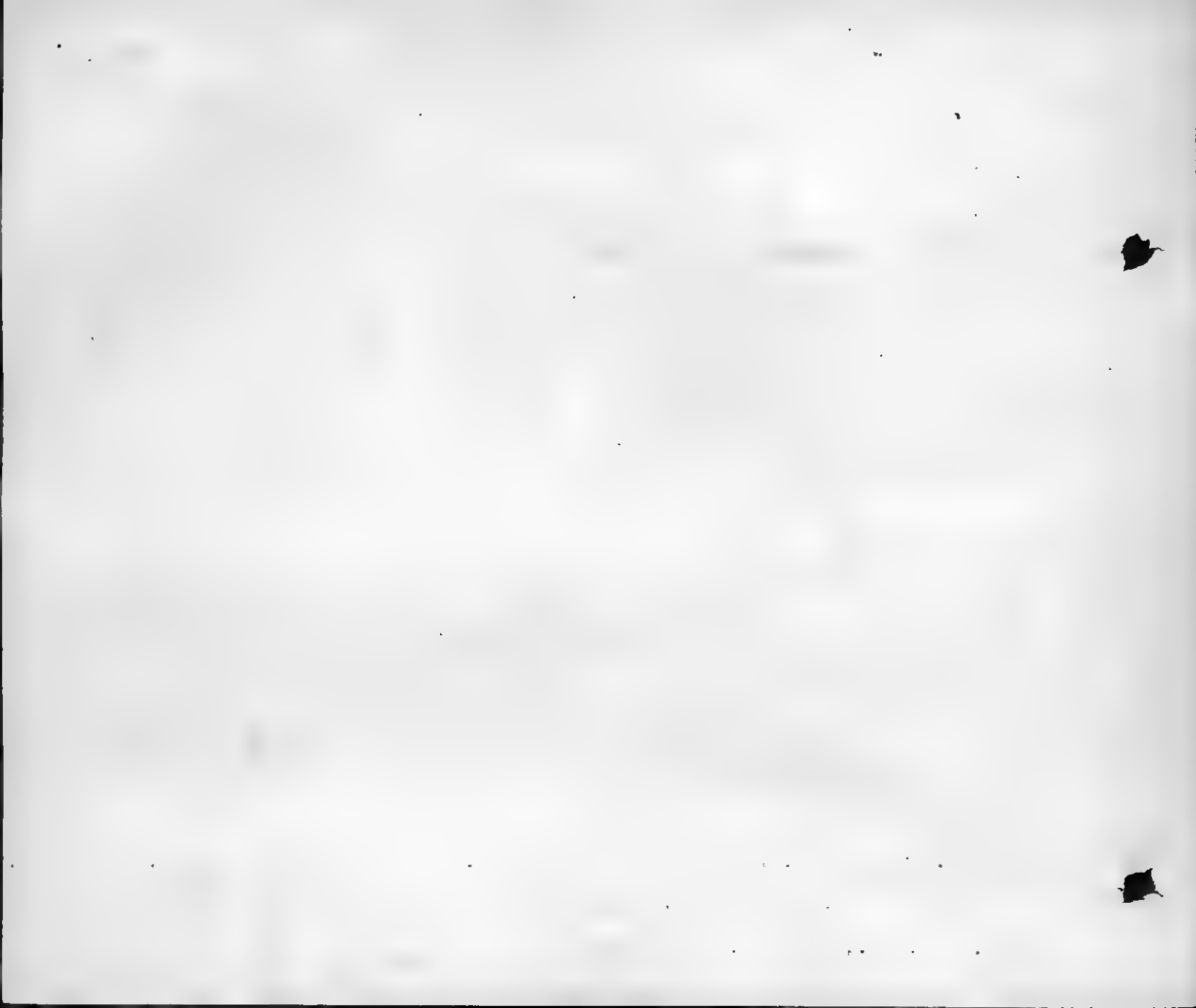


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 6458
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

06442

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Mary' and		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XBALTIMORE 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 14000 NORTH POINT ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First ARTHUR Middle JOHN Last DUNBAR		4. DATE OF DEATH Month 6 - Day 19 - Year 1961	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-17-'98
9 AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR: Months 6 Days 19 Hours 19 Min.		IF UNDER 24 HRS: Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11 BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U.S. 4	
13. FATHER'S NAME GEORGE DUNBAR		14. MOTHER'S MAIDEN NAME HELEN GOUDIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17 INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 000X - FAR ADVANCED PULMONARY TUBERCULOSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 12-5-1960 to 6-19-1961 that (I) (we) last saw the deceased alive on 6-15-1961 and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. Cook, Inc.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) M. Lewcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, (Specify) BURIAL		23b. DATE THEREOF 6-21-61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) _____ (State) _____ Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR JUN 21 '61	
25b. REGISTRAR'S SIGNATURE Carlton S. Kline			

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 15M 9/59



Reg. Dist. No. 06443

1. PLACE OF DEATH a. COUNTY BALTIMORE - 19 MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1241 BEECHWOOD RD		e. STREET ADDRESS 1 #1	
3. NAME OF DECEASED (Type or print) MICHAEL EUGENE DUNCAN		4. DATE OF DEATH Month JUNE Day 3 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12/61
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 22 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID THEODORE DUNCAN		14. MOTHER'S MAIDEN NAME BETTY MAE PERSINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FATHER.		Address AS IN #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE BRONCHO PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNDERWEIGHT AT BIRTH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1961 to June 3, 1961 , that I last saw the deceased alive on June 2, 1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis N. Tollin		ADDRESS (Street, city or town, state) 6908 N. Pt. Rd. MD.	
DATE SIGNED 6/3/61			
PHYSICIAN'S NAME (Type) LOUIS N. TOLLIN		BALTIMORE - 19 - MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/61	
22c. NAME OF CEMETERY OR CREMATORY BelAir Memorial Gardens		22d. LOCATION (City, town, or county) (State) BelAir, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE JUN 6 '61	
24b. REGISTRAR'S SIGNATURE William J. Kraus			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

FLORIDA DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0460

06444

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1102 Frederick Ave		d. STREET ADDRESS 1102 Frederick Ave	
3. NAME OF DECEASED (Type or print) Willie M. Early		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0
13. FATHER'S NAME Amorn Cooper	14. MOTHER'S MAIDEN NAME Mary E. Cooper	12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMATION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 122.1 DUE TO		144. 15 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/16/1943 to 6-21-1961 , that (I) (we) last saw the deceased alive on 6-20-1961 , and that death occurred 21-6-1961 from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher	22b. DATE SIGNED	22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher	
22d. ADDRESS 6209 Frederick Rd, Baltimore-28, Md.		22e. REC'D BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Cremated		6-23-61	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Harley Cemetery		Weyensboro Va	
24. FUNERAL DIRECTOR'S SIGNATURE Harley Curran		25. REC'D BY REGISTRAR DATE JUN 26 '61	
25b. REGISTRAR'S SIGNATURE William S. Hanna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

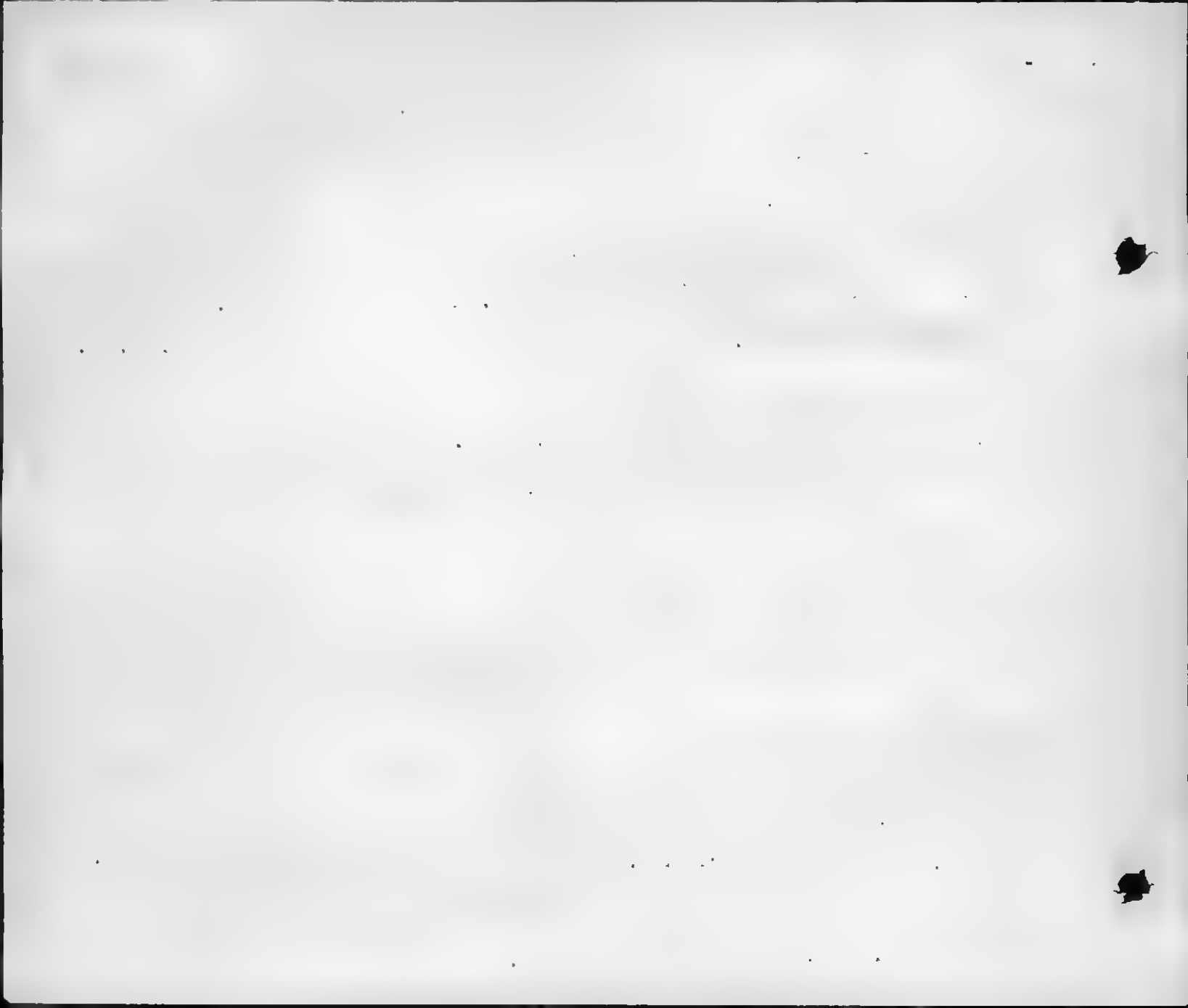
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6461

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06445

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1227 Francis Avenue		d. STREET ADDRESS 1227 Francis Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last William Herbert Eckart		4. DATE OF DEATH Month Day Year June 1, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1907
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ornamental Iron Mfg.		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Eckart		14. MOTHER'S MAIDEN NAME Jane Grace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-09-7807	
17. INFORMANT Rose H. Eckart		Address 1227 Francis Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 5 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15, 1961 to June 1, 1961 , that (I) (we) last saw the deceased alive on June 1, 1961 , and that death occurred at 9:15 M, from the causes and on the date stated above			
22a. SIGNATURE A. Bradley Daugharthy 22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy, M. D.		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1264 Francis Avenue; Balto. 27, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 6/5/61	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City, town, or county) (State) Elrkidge, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR JUN 5 '61 25b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06446

6462

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>11419 Reisterstown Road</u>		d. STREET ADDRESS <u>11419 Reisterstown Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>CARRIE A. ECKENRODE</u>		4. DATE OF DEATH <u>June 29 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1878</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>83</u> yrs.	9c. IF UNDER 1 YEAR <u>Months</u> Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Thompson</u>	
14. MOTHER'S MAIDEN NAME <u>Mary ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr Chas. H. DeVos</u> Address <u>Same as deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>31X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> DUE TO (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 1957</u> to <u>June 29, 1961</u> , that I last saw the deceased alive on <u>June 29, 1961</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. Williams</u>		ADDRESS (Street, city or town, state) <u>M.D. 1180 of Reisterstown Rd, Reisterstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Clarence E. Williams</u>		DATE SIGNED <u>June 29, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/1/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		24a. RECEIVED BY REGISTRAR <u>DATE JUL 3 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

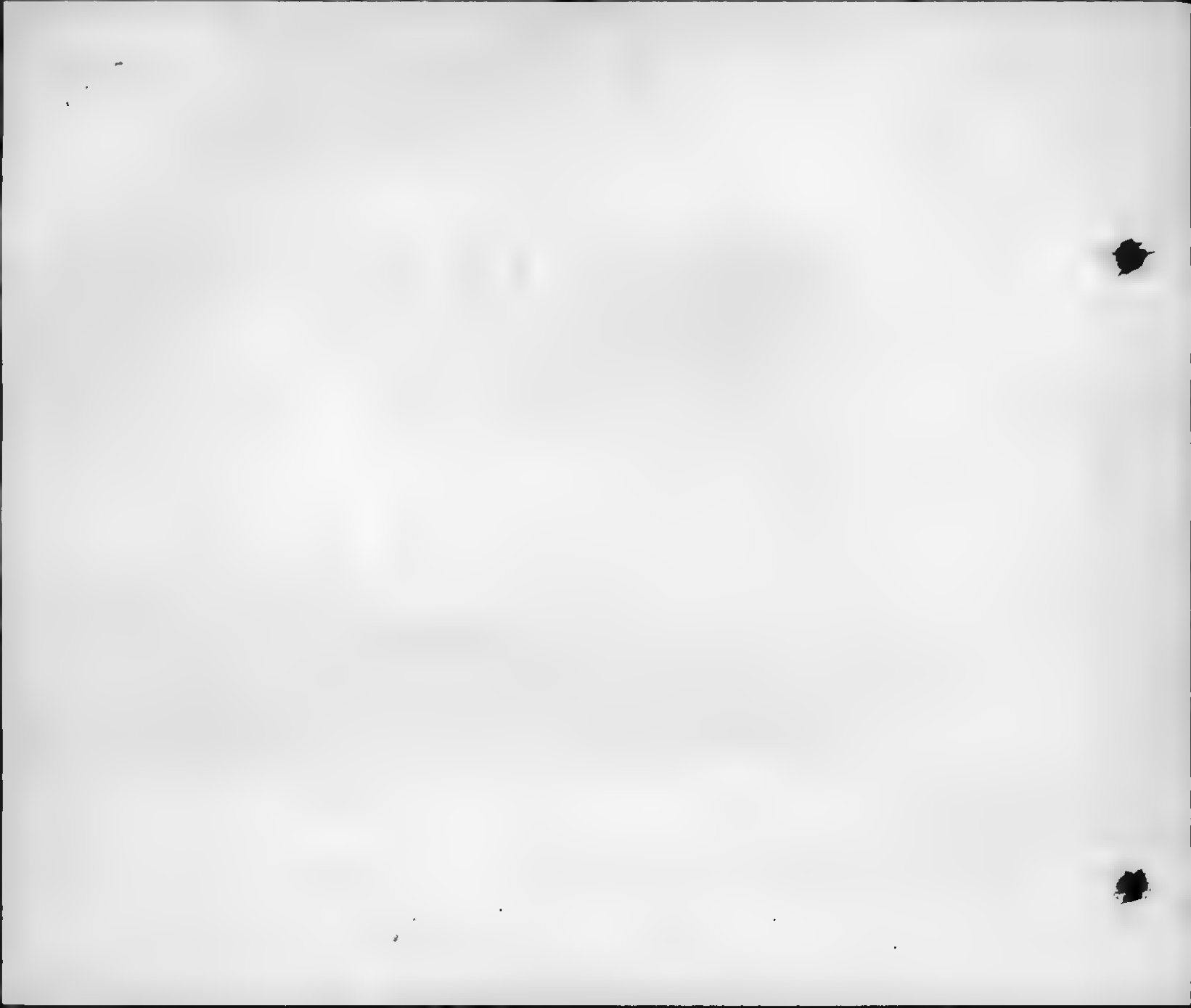
Reg. Dist. No. **06447**

6463

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission). a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>Mountain Road, Jacobsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House In The Pines Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gustavo</u> Middle <u>W.</u> Last <u>Ehrecke, Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28th Nov. 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elec. Eng. (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kansas City Pub. Serv.</u>		11. BIRTHPLACE (State or foreign country) <u>Wausau, Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard Ehrecke</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Giesler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>486-075-448A</u>		17. INFORMANT <u>G. Wm. Ehrecke, Jr.</u> Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>351X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile dementia with Cortical atrophy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6/17/1961</u> to <u>6/20/1961</u> , that I last saw the deceased alive on <u>6/20/1961</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u>				DATE SIGNED <u>6/20/61</u>			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>							
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				<u>Baltimore, 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>23rd June '61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chatham Center Rural Bm.</u>		22d. LOCATION (City, town, or county) (State) <u>Chatham, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Suptela</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, on in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

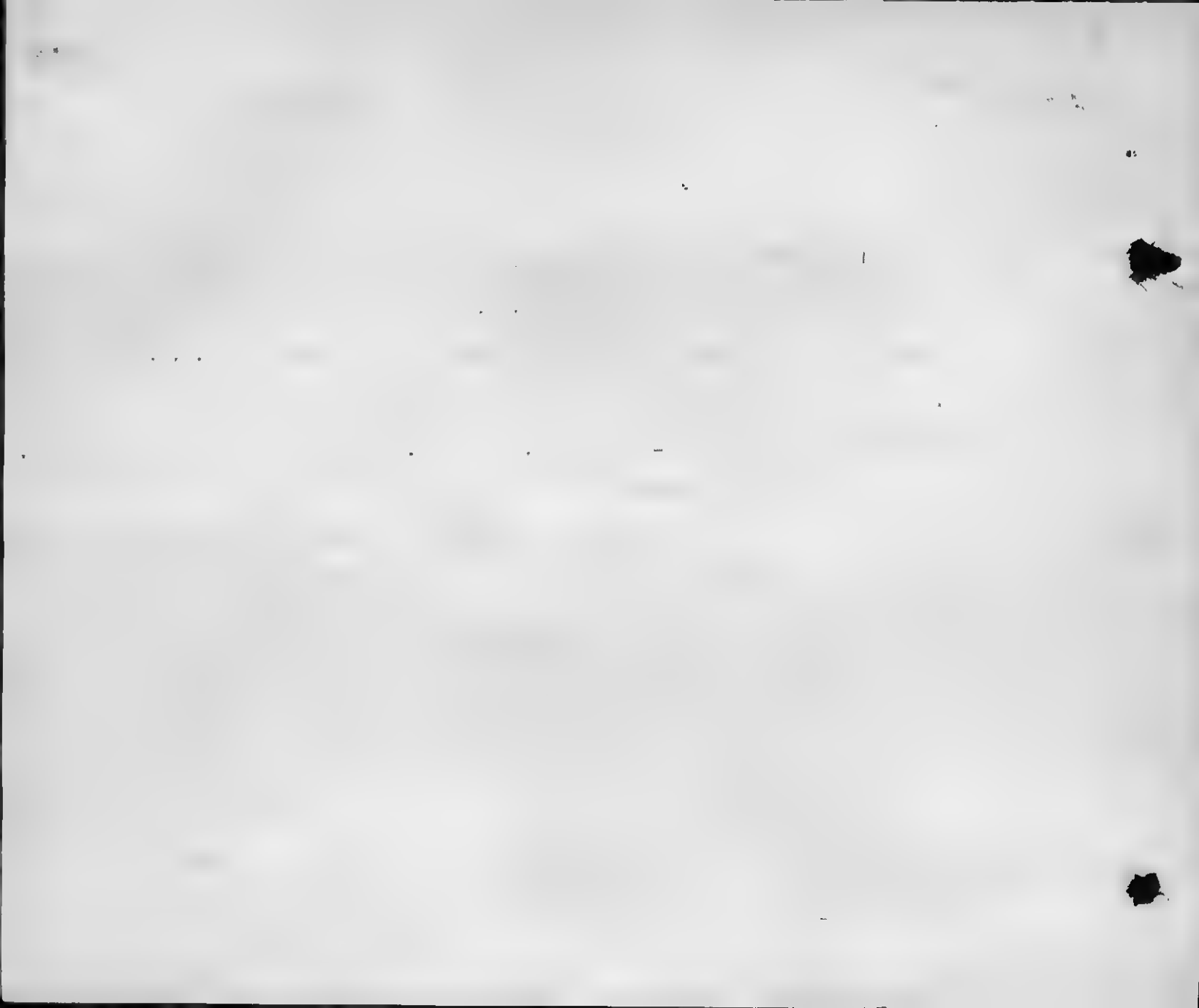
06448

6464

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> c. LENGTH OF STAY IN lb. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 3 Box 273</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> d. STREET ADDRESS <u>Route # 3 Box 273</u>	
3. NAME OF DECEASED (Type or print) <u>VERNON LOUIS ELY</u>		4. DATE OF DEATH <u>June 1, 1961</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>	11. BIRTHPLACE (Country & State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John C. Ely</u>		14. MOTHER'S MAIDEN NAME <u>Grace ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-18-7468</u>	
17. ADDRESS <u>Mrs. Vernon L. Ely-Route # 3 Box 273 - Arnold, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Subacute Bacterial Endocarditis</u> DUE TO (c) <u>Rheumatic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)	
20g. (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2-15-49</u> , to <u>5-31-61</u> , that (I) (we) last saw the deceased alive on <u>5-31-1961</u> , and that death occurred at <u>5-31-1961</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>6-1-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M. SHIPLEY</u>		22d. ADDRESS <u>Annapolis, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-3-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City, town or county) <u>Woodlawn, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>North Avenue</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>June 2 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/68



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06449

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Admiral Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle JANE Last EVANS		4. DATE OF DEATH Month June Day 13 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 9, 1839
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USJA: OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Rees		14. MOTHER'S MAIDEN NAME Elizabeth Davies	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Dr. Eugene Evans 1 Liberty Pkwy-22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Hypertensive Cardio-Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 11, 1961 to June 13, 1961 , that I last saw the deceased alive on June 11, 1961 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lester Lebo		ADDRESS (Street, city or town, state) 1801 Enoch Pl. Balto 17, Md.	
PHYSICIAN'S NAME (Type) LESTER LEBOWITZ		DATE SIGNED 6/14/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1961	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06450**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 28 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 708 "E" Street				d. STREET ADDRESS 708 "E" Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last W. L. Ford Bateman FAIRBANK				4. DATE OF DEATH Month Day Year June 4, 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 7, 1901		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Frank Fairbank				14. MOTHER'S MAIDEN NAME Annie White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213 01 8966		17. INFORMANT Address J. Harry Fairbank, Tilghman, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CA of Lower bowel							
20a. EXTERNAL CAUSE, WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/61		22c. NAME OF CEMETERY OR CREMATORY Fairbank Cemetery		22d. LOCATION (City, town, or county) (State) Fairbank, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE St. Michaels, Md				24a. REC'D BY REGISTRAR JUN 8 '61		24b. REGISTRAR'S SIGNATURE William E. Kneass	

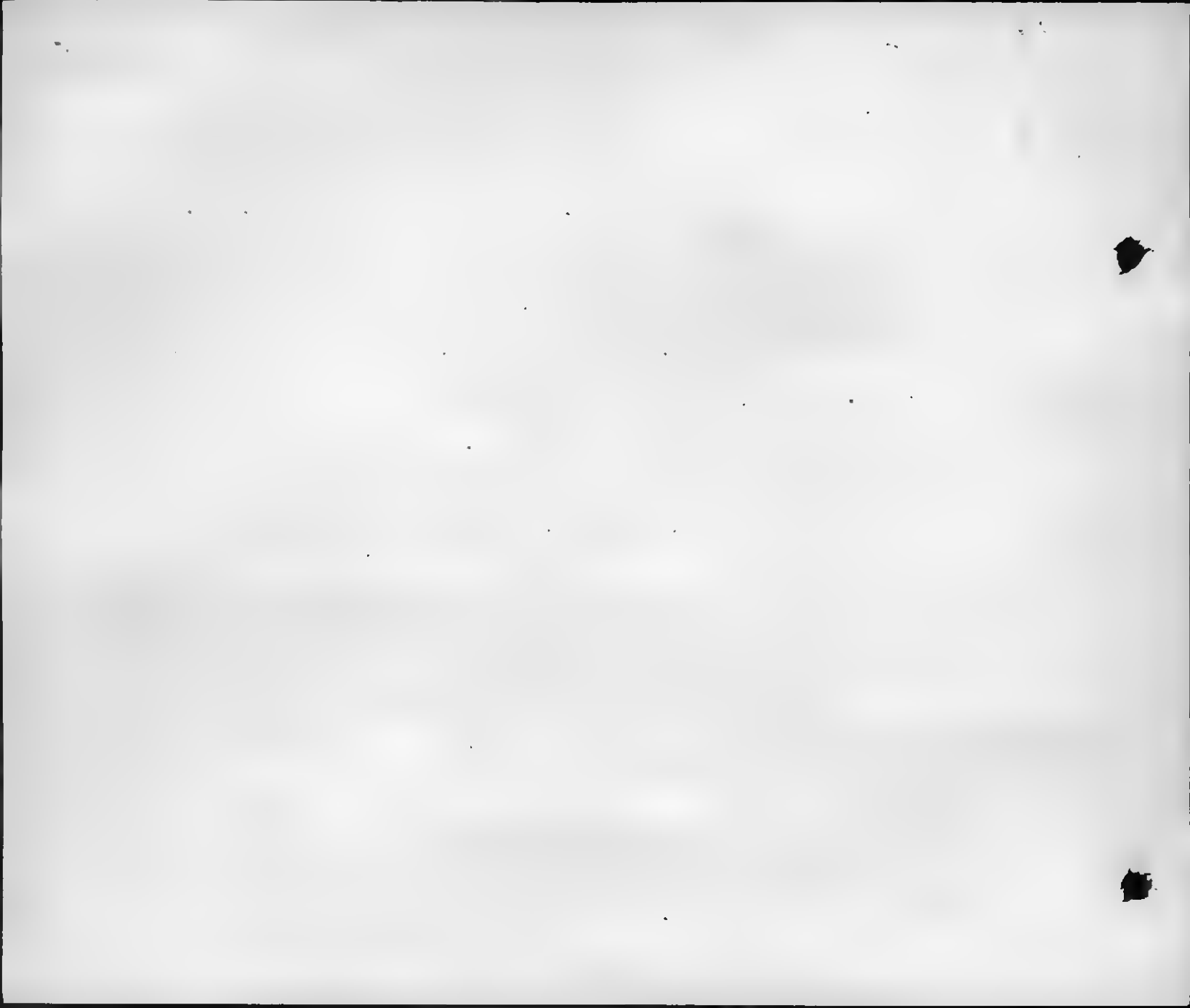


CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6467

06451

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1518 Riderwood- Lutherville Dr.				d. STREET ADDRESS 1518 Riderwood-Luth. Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Eugene Fendlay		First Middle Last		4. DATE OF DEATH Month 6 Day 14 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1875		9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months 6 Days 14	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Penn. Rail Road		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James B. Febdlay				14. MOTHER'S MAIDEN NAME Mary Dorerr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. ?????		17. INFORMANT Harry F. Fendlay Address 1518 Luth- Riderwood Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cerebrovascular disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 12 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1956 to 6/14/1961 , that (I) (we) last saw the deceased alive on 6/14/1961 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles F. O'Donnell</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/15/61	
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell				22d. ADDRESS 7501 York Rd Towson 4 Md			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-61		23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery		23d. LOCATION (City, town, or county) (State) Texas, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Maryland				25a. REC'D BY REGISTRAR JUN 20 '61		25b. REGISTRAR'S SIGNATURE <i>Charles E. Harris</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

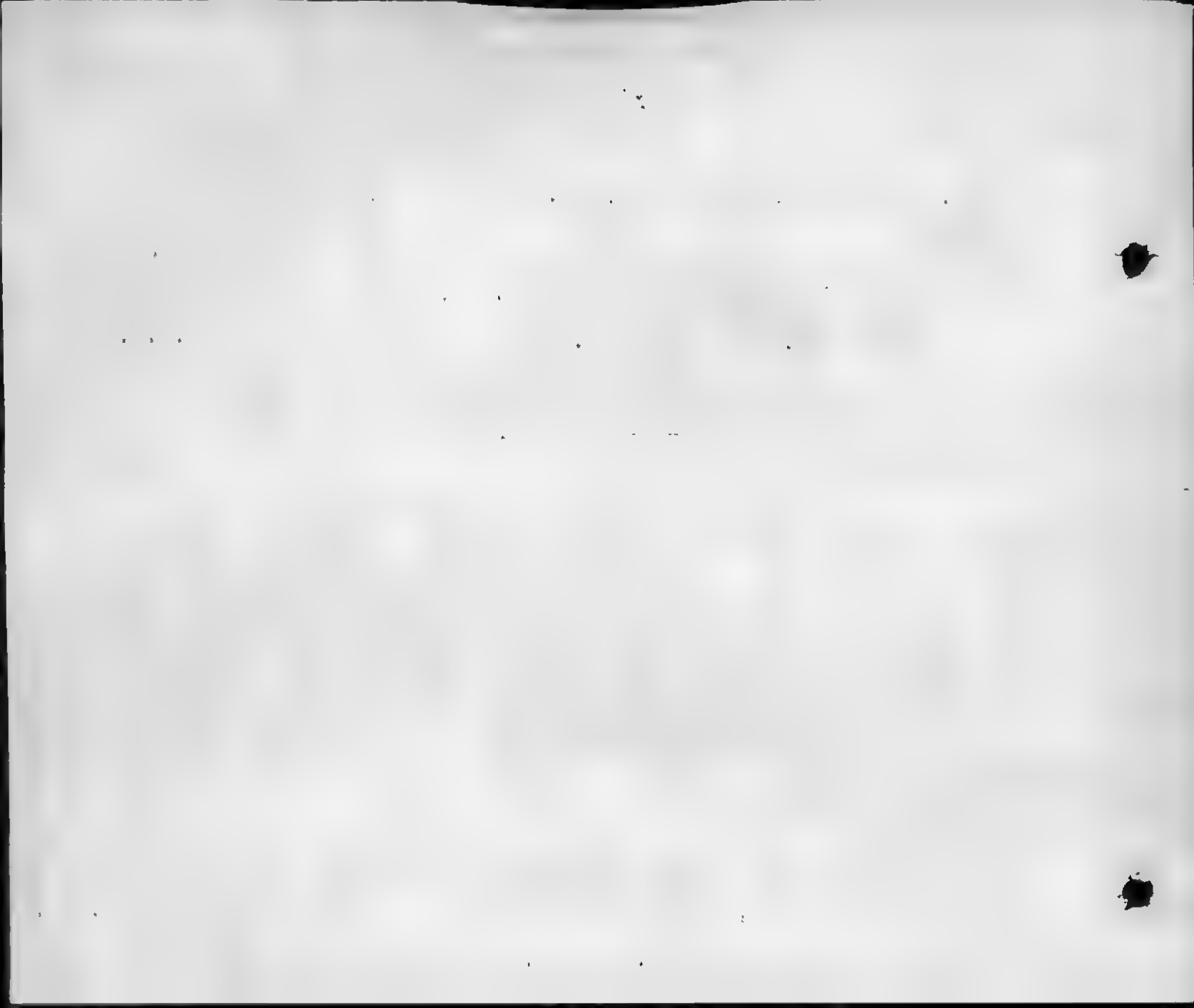
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06452**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN TB 5 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 21 Leeway, Dundalk 22, Md.				d. STREET ADDRESS 21 Leeway, Dundalk 22, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adeline Finn				4. DATE OF DEATH June 10, 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28, 1894		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pomato Pckg.		10b. KIND OF BUSINESS OR INDUSTRY Geffalo Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Roberto				14. MOTHER'S MAIDEN NAME Emily Bassett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-10-3142		17. INFORMANT Mrs. Catherine Falkenhan 21 Leeway 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 Men. 6 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE JACK COLLINS				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-10-61	
EXAMINER'S NAME (Type) JACK COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 14, 1961		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.				24a. REC'D BY REGISTRAR DATE JUN 13 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please e-mail the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06453

6469

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (7)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			

3. NAME OF DECEASED (Type or print) VERNON L. FINNEGAN		4. DATE OF DEATH June 23 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 23, 1890	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (Country & State, or foreign country) Pikesville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13. FATHER'S NAME Thomas Finnegan		14. MOTHER'S MAIDEN NAME Catherine White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW I		16. SOCIAL SECURITY NO. 212-07-1150	
17. INFORMANT Clinical Records, VA Hospital, Baltimore 18, Maryland, Fort Howard Division			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO 1810 Conditions, if any, which gave rise to immediate cause (b) CARCINOMA OF BLADDER (c), stating the underlying cause last. DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
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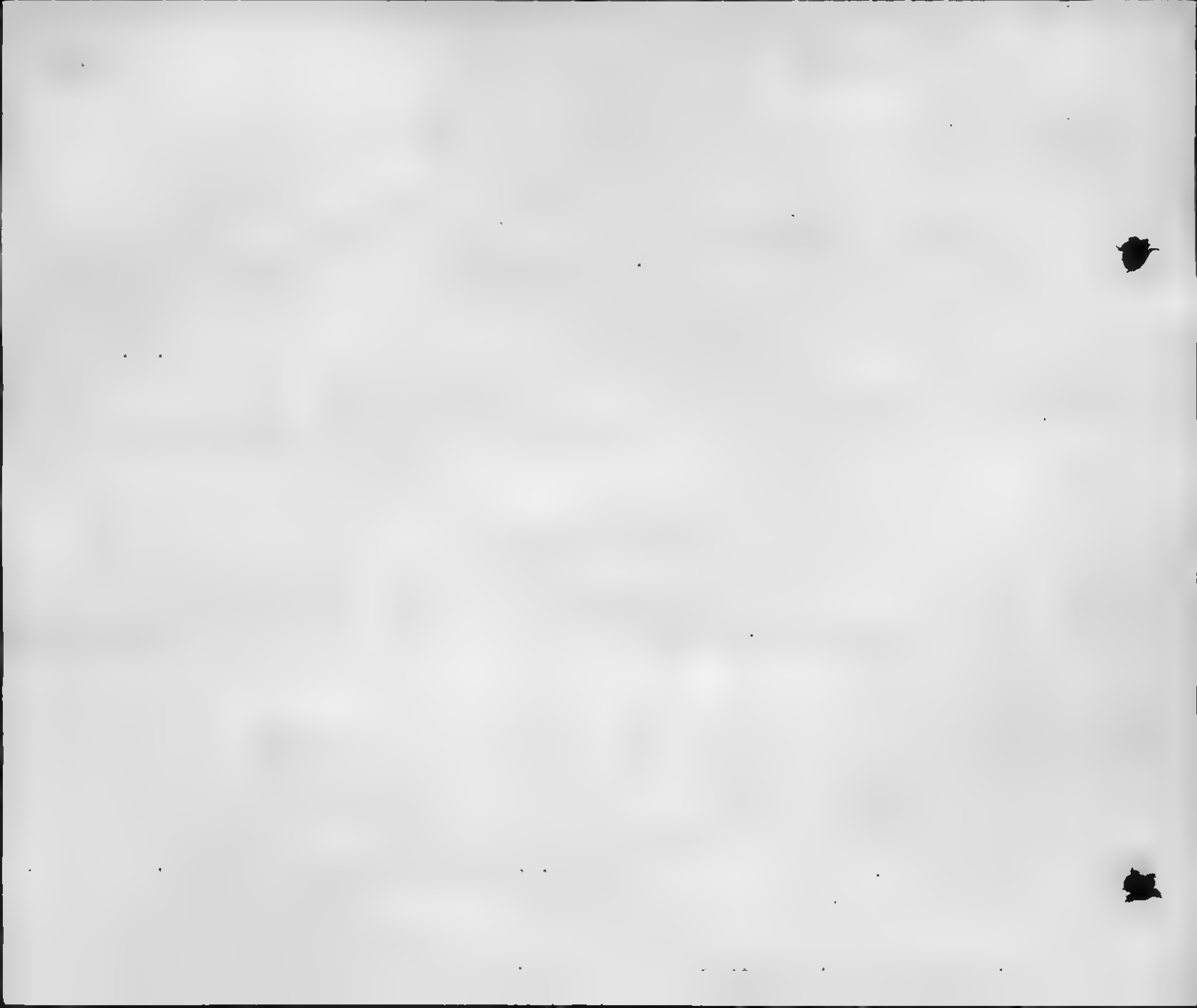
21. I certify that (X) (this hospital) attended the deceased from June 20, 1961 to June 23, 1961, that (X) (we) last saw the deceased alive on June 23, 1961, and that death occurred at 5:20 P.M. from the causes and on the date stated above.			
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22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 6/23/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN		22d. ADDRESS M.D. VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF JUNE 25 1961		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schwab, 3512 Frederick Ave. Balto. Md.				25a. REC'D BY REGISTRAR DATE JUN 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



CERTIFICATE OF DEATH

Reg. Dist. No. 06454

1. PLACE OF DEATH a. COUNTY <u>Catonsville Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> COUNTY <u>QA Co Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Freetown Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		d. STREET ADDRESS <u>Baltimore Md 02X-</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>John Charles Fischer</u>				4. DATE OF DEATH Month Day Year <u>June 11 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28 - 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Fischer</u>				14. MOTHER'S MAIDEN NAME <u>Frances Reahe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-32-8025</u>		INFORMANT Address <u>Mrs Mary Fischer 5200 B 98th Baltimore 25 Md</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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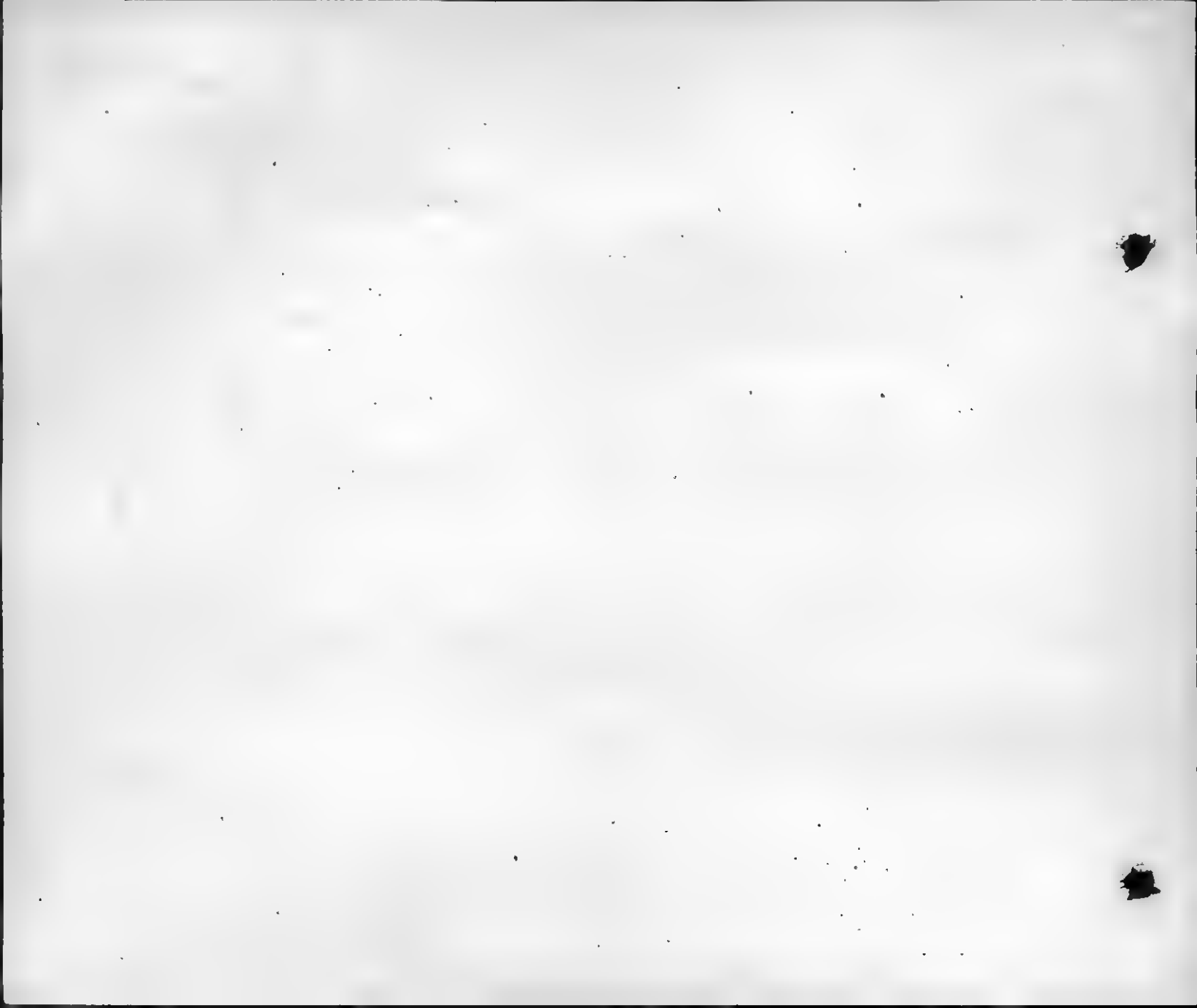
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>March 29, 1961</u> to <u>June 11, 1961</u> , that I last saw the deceased alive on <u>June 9, 1961</u> and that death occurred at <u>5:25 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Bahram Sina</u> M.D.	ADDRESS (Street, city or town, state) <u>534 Camp Meade Rd</u> DATE SIGNED <u>June 13-61</u>
PHYSICIAN'S NAME (Type) <u>BAHRAM SINA MD.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 14-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Medford Rd Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Belmont G. Tink</u> ADDRESS <u>Bel Air home Md</u>		24a. REC'D BY REGISTRAR <u>JUN 15 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

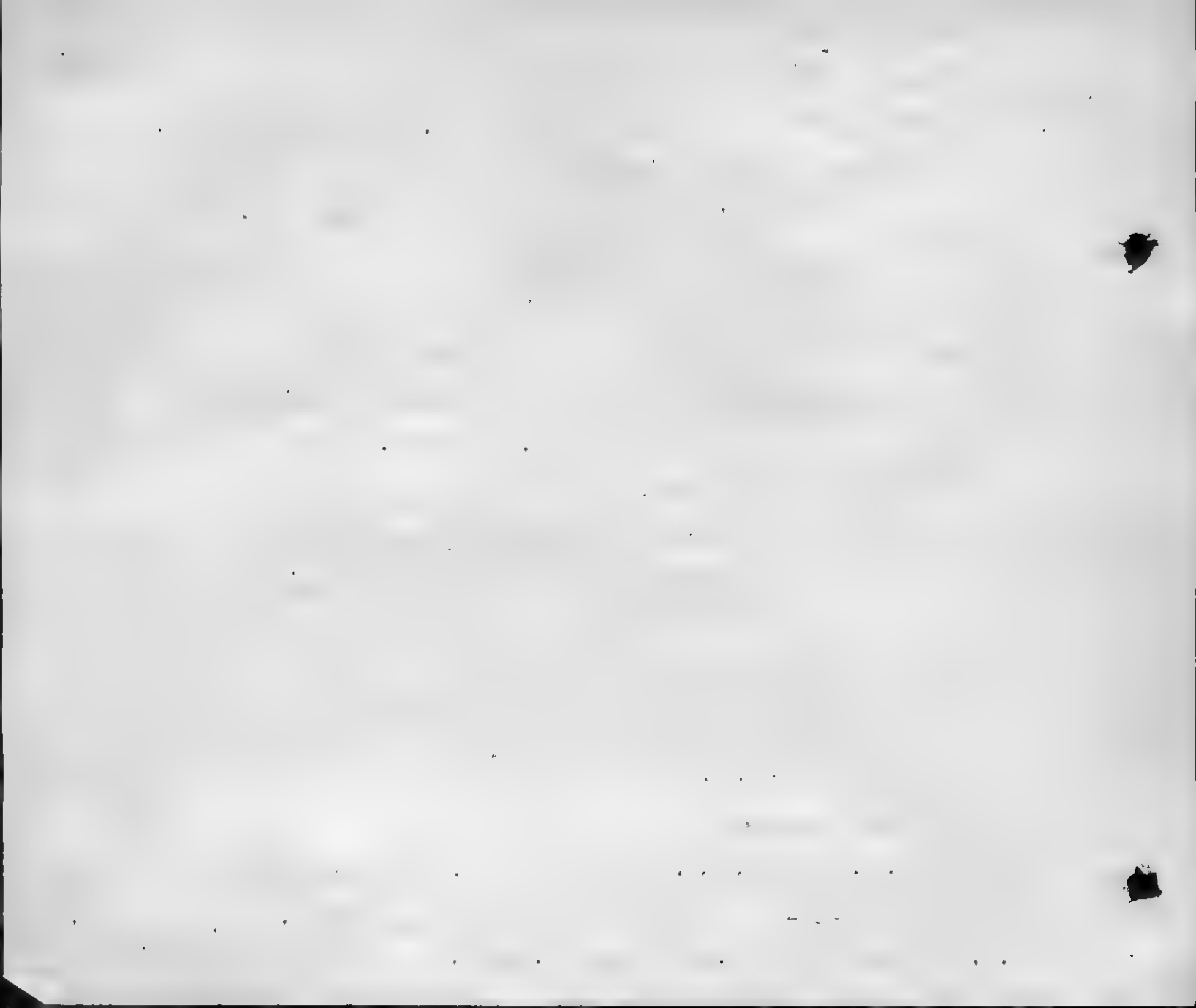
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06455

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton c. LENGTH OF STAY IN b. Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1714 Ruxton Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton d. STREET ADDRESS 1714 Ruxton Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles 4. DATE OF DEATH 6 17 1961		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5-31-1880 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR: Months 6 Days 17 Hours 17 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Frank Fisher 14. MOTHER'S MAIDEN NAME Frances Virginia Poor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Mrs. Nannie H. Fisher Address Above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal Pneumonia (Lobar) Pulmonary oedema 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with auricular fibrillation DUE TO (c) Severe generalized arteriosclerosis, cerebral arteriosclerosis, gangrene both feet (arteriosclerotic) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 3 weeks INTERVAL BETWEEN ONSET AND DEATH 1 week 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 18 E. Eager Street 20f. [City or town] Balto. (County) Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1950 , 19., to death , 19. 61 that (I) (we) last saw the deceased alive on 4 P. M. , 19. 61 , and that death occurred 4:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE B. H. Rutledge, M.D. 22c. PHYSICIAN'S NAME (Type) B. H. Rutledge, M.D. 22d. ADDRESS 18 E. Eager Street		22b. DATE SIGNED 6/19/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6-19-61 23c. NAME OF CEMETERY OR CREMATORY Greenmount 23d. LOCATION (City, town or county) Balto. (State) Md.		24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 25a. REC'D BY REGISTRAR 4905 York Rd. Balto. 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus DATE JUN 20 '61	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0472

06456

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> COUNTY <u>Baltimore</u> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>104 Smithwood Ave</u> g. STREET ADDRESS <u>Catonsville 28</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOSEPH C. FLORA</u> First Middle Last		4. DATE OF DEATH <u>6/8</u> 19 <u>61</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/29/74</u> 86 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>6</u> Days <u>8</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Fred Flora</u>		14. MOTHER'S MAIDEN NAME <u>Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. Address <u>Smith</u>		17. INFORMANT Address <u>Smith</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute & chronic congestive Heart Failure</u> DUE TO (b) <u>Degenerative Heart Disease</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>6/8/61</u> to <u>6/8/61</u> , that (I) (we) last saw the deceased alive on <u>6/8/61</u> , and that death occurred <u>6/8/61</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.E. McGrath</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath</u>				22b. DATE SIGNED <u>6/9/61</u> 22d. ADDRESS <u>1303 Frederick Rd Catonsville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>			
23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

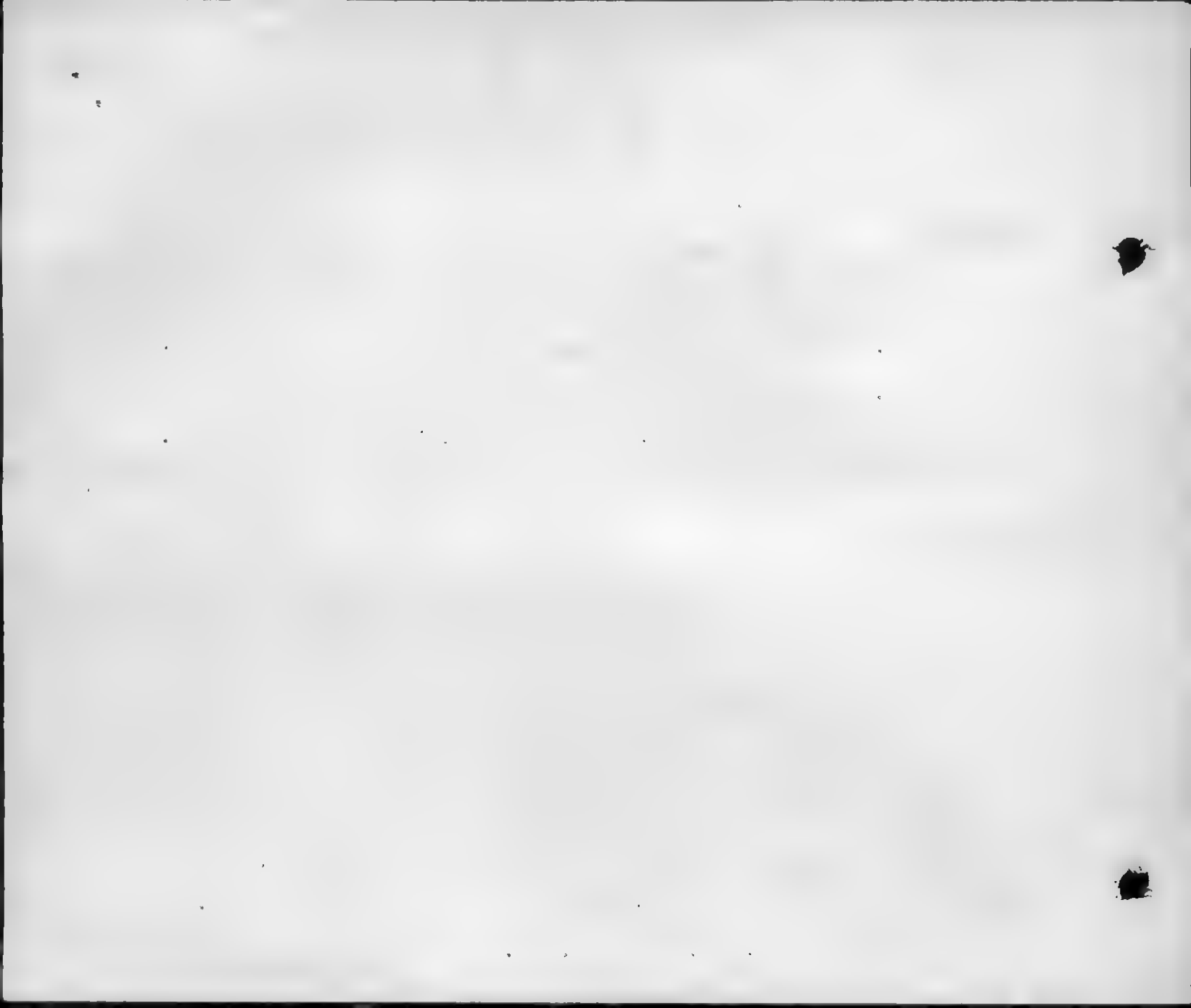
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



ma retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
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M
X
6473
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06457

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Butler				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Falls Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM ARTHUR FOWBLE, SR.				4. DATE OF DEATH Month 6 Day 2 Year 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-1894	9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months 6 Days 1 Hours 19	IF UNDER 24 HRS Hours 19 Min 19	
10a. US. JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) self empl. sales		10b. KIND OF BUSINESS OR INDUSTRY real estate		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis M. Fowble				14. MOTHER'S MAIDEN NAME Susie Frank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-05-1697		17. INFORMANT Grace A. Fowble, Butler, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of abdominal 199X DUE TO recess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia DUE TO (c) Cachexia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 18 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-10-60 to 6-2-61 that (I) (we) last saw the deceased alive on 5-17-61 and that death occurred at 4 PM from the causes and on the date stated above							
22a. SIGNATURE James G. Saffell				22b. DATE SIGNED 6-2-61			
22c. PHYSICIAN'S NAME (Type) James G. Saffell				22d. ADDRESS Reisterstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-5-61		23c. NAME OF CEMETERY OR CREMATORY Black Rock		23d. LOCATION (City, town, or county) (State) Butler, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson, Md.				25a. REC'D BY REGISTRAR DATE JUN 8 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

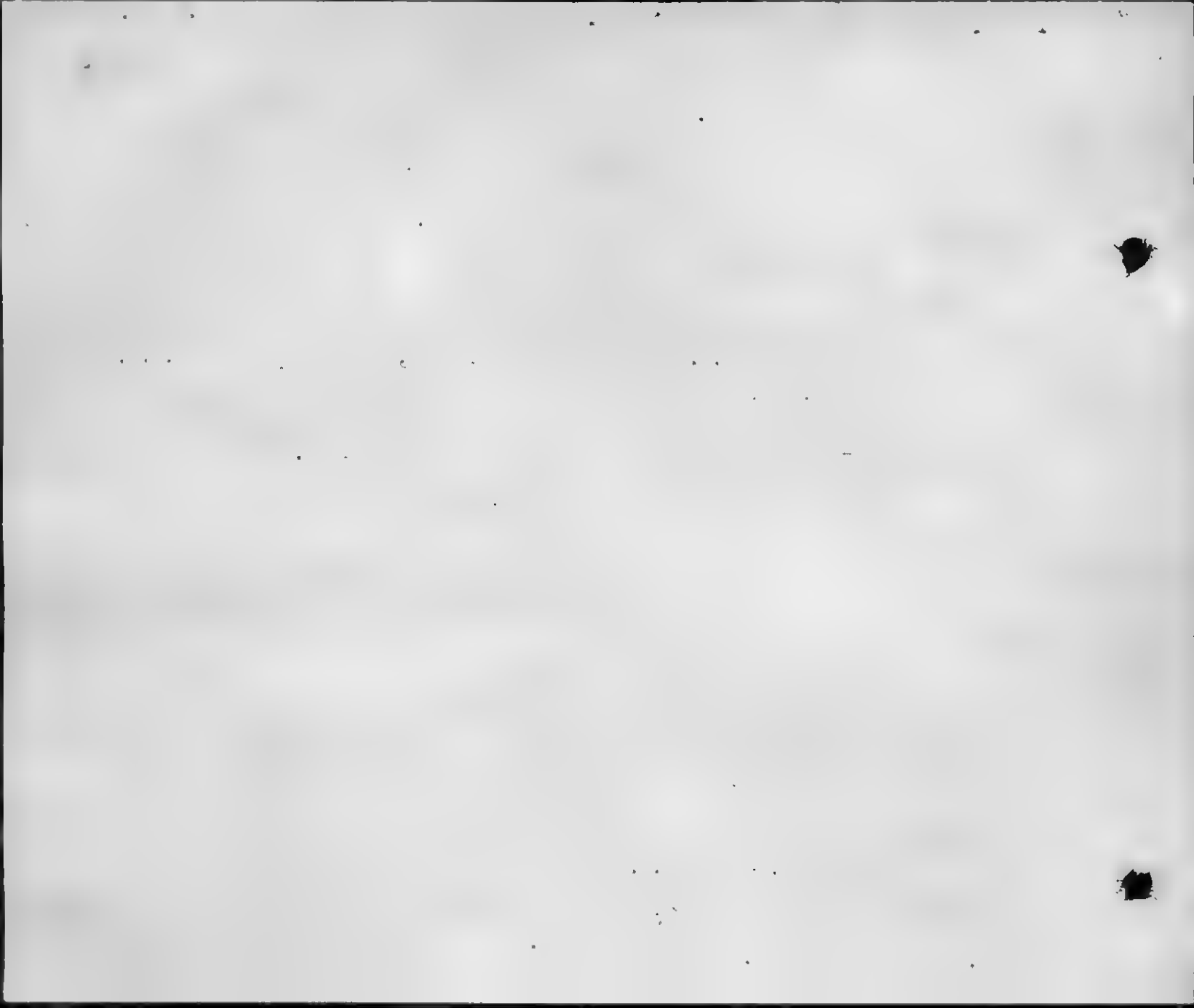
06474

06458

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>06458</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>248 S. Duncan Street - 31</u>			
3. NAME OF DECEASED (Type or print) <u>CHRISTOPHER J. FRIEL</u>				4. DATE OF DEATH <u>June 3 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1897</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Hours <u>61</u> Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>WW-1</u>				17. INFORMANT <u>Clinical Records, VAH 3900 Loch Raven Boulevard, Balto 18, Md. FORT HOWARD DIVISION</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EPIDERMOID CARCINOMA, LEFT PHARYNX</u> DUE TO (b) <u>1 + 8 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 + 8 X</u> DUE TO (c) <u>1 + 8 X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 9, 1961</u> to <u>June 3, 1961</u> , that <u>20</u> (we) last saw the deceased alive on <u>June 3, 1961</u> , and that death occurred at <u>10:50 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Norman P. Jones</u>				22b. DATE SIGNED <u>6/3/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>NORMAN P. JONES, M.D.</u>				22d. ADDRESS <u>VAH Fort Howard, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc. Baltimore, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUN 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

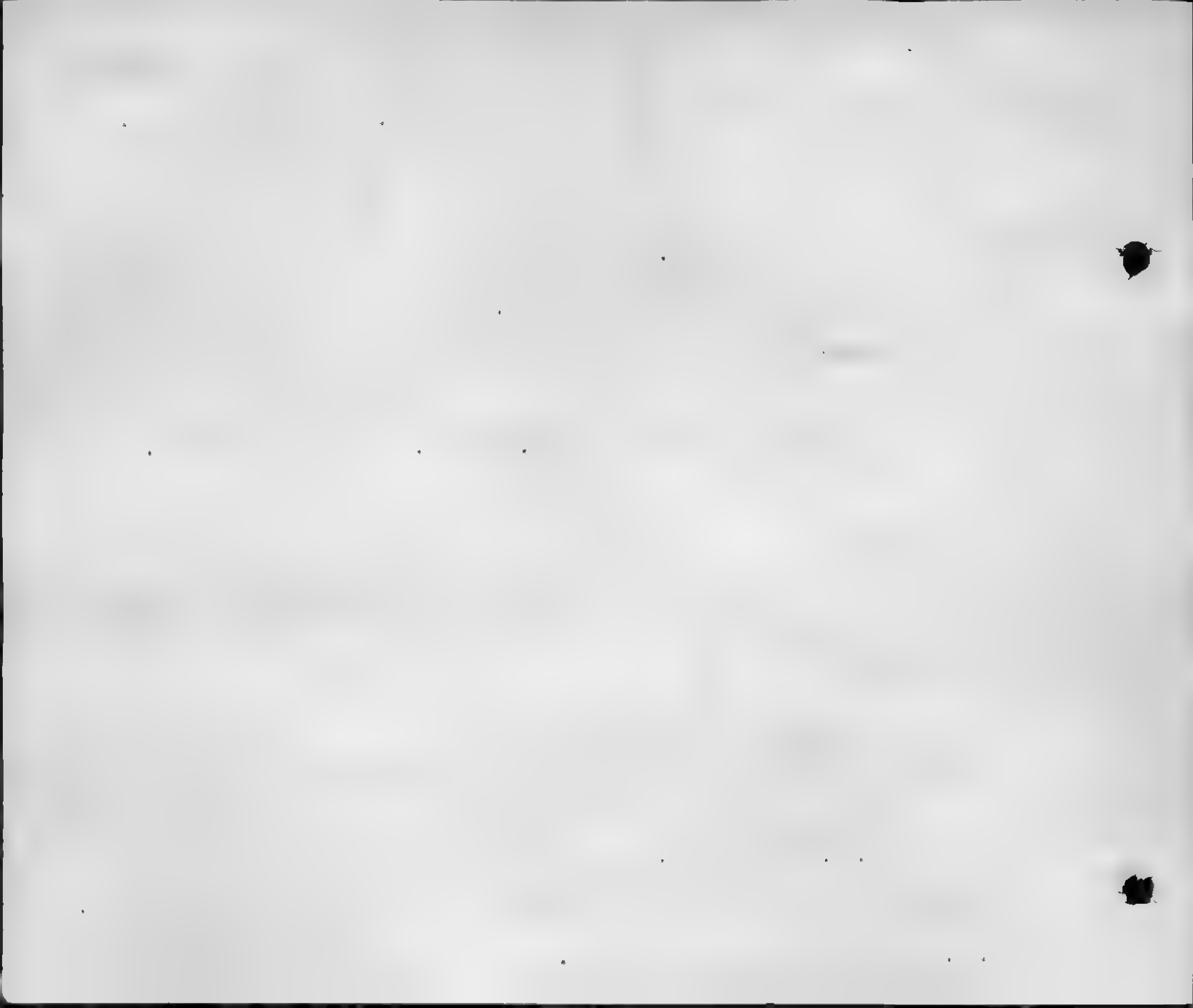


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06459									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>458 Main Street</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>458 Main Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Charles R. Fuss</u>					4. DATE OF DEATH Month <u>June</u> , Day <u>8</u> , Year <u>19 61</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 28, 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Albert Fuss</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Woods</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>215-01-4688 A</u>		17. INFORMANT <u>Mrs. Edith E. Fuss Reisterstown, Md.</u>		18. CRUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 1201 DUE TO (b) <u>1201</u> DUE TO (c) <u>1201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive C-V Disease</u>		21. I certify that (I) <u>(M.D.)</u> attended the deceased from <u>6-12-45</u> , 19 <u>45</u> , to <u>6-8-61</u> , 19 <u>61</u> , that (I) <u>(M.D.)</u> last saw the deceased alive on <u>5-11-61</u> , 19 <u>61</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>A. D. Caples</u> M.D.		22b. DATE SIGNED <u>6-9-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u>		22d. ADDRESS <u>6 Hanover Rd., Reisterstown, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 10, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
23d. LOCATION (City, town or county) <u>Pikesville</u>		23e. (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>		24b. ADDRESS <u>Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR <u>June 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>		25c. DATE <u>June 12 '61</u>		25d. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>		25e. DATE <u>June 12 '61</u>		25f. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

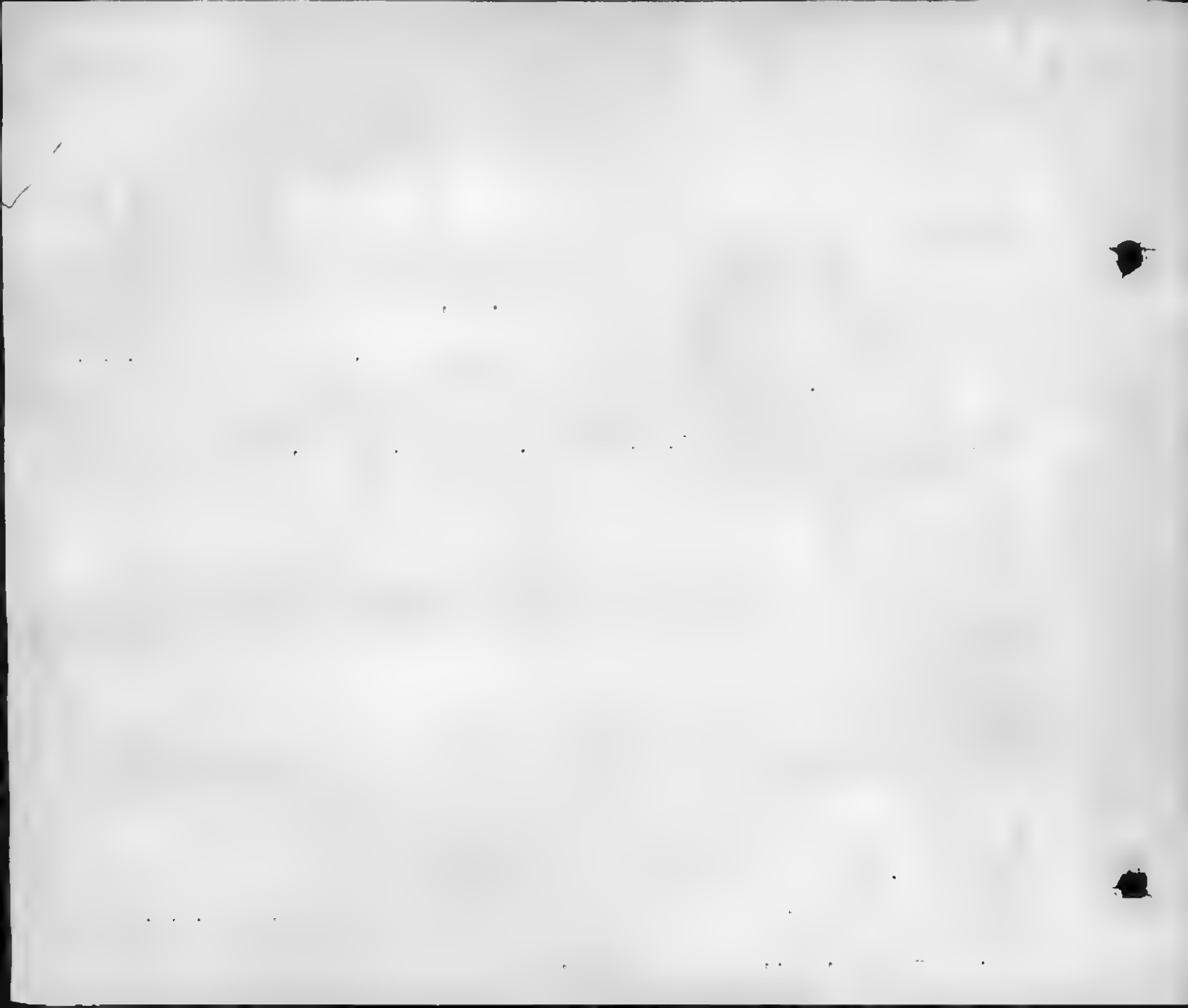
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06460**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Baltimore 6		Baltimore 6	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Chk Grndz 8715 - 11 Maple Ave		5521 Ritter Avenue	
4. NAME OF DECEASED (Type or print)		5. DATE OF DEATH	
George		June 27 19 61	
6. SEX male		7. AGE (In years last birthday) 59	
8. COLOR OR RACE white		9. IF UNDER 1 YEAR	
10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. IF UNDER 24 HRS	
12. DATE OF BIRTH Sept. 23, 1901		13. Months Days Hours Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. KIND OF BUSINESS OR INDUSTRY	
Maintenance		Apt. Bldg	
16. BIRTHPLACE (State or foreign country)		17. CITIZEN OF WHAT COUNTRY?	
Baltimore, Maryland		U.S.A.	
18. FATHER'S NAME John L. George		19. MOTHER'S MAIDEN NAME Elizabeth Hare	
20. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		21. SOCIAL SECURITY NO	
no		216-09-6600	
22. INFORMANT		Address	
Mrs. Maudie P. George		Zone 6	
23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Excess 42201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
24. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		25. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
None		None	
26. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		27. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20	
28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		29. (City or town) (County) (State)	
20		20	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M B Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/29/61	
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF	
BURIAL		6-30-61	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Meadowridge Cemetery		Elkridge, Md. R.F.D.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Wm. Cook-Towson, Inc., 1050 York Road, Towson		DATE JUL 3 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Wm. Cook-Towson, Inc., 1050 York Road, Towson		Arthur S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06461

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>238 ROLLINGBROOK WAY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>238 ROLLINGBROOK WAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WARREN GETZ</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-6-1919</u> 9. AGE (In years last birthday) <u>42</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chem. Eng. Food MACH.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward M. Getz</u> 14. MOTHER'S MAIDEN NAME <u>Florence Phelps</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>121-01-2368</u> 17. INFORMANT <u>Katie Getz</u> Address <u>BALTO 28</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6-18-61</u> to <u>6-18-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-18-61</u> , 19 <u>61</u> , and that death occurred at <u>6:18</u> A.M., from the causes and on the date stated above. 22a. SIGNATURE <u>Justina Kudirka</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>Justina Kudirka</u> 22d. ADDRESS <u>1709 Edmonson ave Catonsville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>6-21-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>PROSPERITY HILL</u> 23d. LOCATION (City, town or county) (State) <u>Blowersville N.Y.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Mal Nabb & Son</u> ADDRESS <u>CATONSVILLE 28, MD</u> 25a. REC'D BY REGISTRAR <u>DATE JUN 22 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH BY A HOSPITAL OR ATTENDING PHYSICIAN. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH BY A HOSPITAL OR ATTENDING PHYSICIAN. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH BY A HOSPITAL OR ATTENDING PHYSICIAN.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

6673

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06462

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 3 1/2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 4343 SUTHERLAND AVE	
3 NAME OF DECEASED (Type or print) First ELIZABETH Middle GIORGIA Last BAR		4. DATE OF DEATH Month JUNE Day 2 Year 1961	
5 SEX FE	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-1868
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDWEAVE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME AUGUST HAINZE		14. MOTHER'S MAIDEN NAME MARIE SHER.	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Frank L. Smith Jr., Cockeysville Md.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease (c) 4 years			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 10:4 1961 to 6-2 1961 , that (I) (we) last saw the deceased alive on 6-2 1961 , and that death occurred at 8:00 PM , from the causes and on the date stated above			
22a SIGNATURE Walter T. Kees M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b DATE SIGNED 6/2/61	
22c PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	23b DATE THEREOF 6-5-61	23c NAME OF CEMETERY OR CREMATORY Schwartz's Cemetery	23d LOCATION (City, town, or county) (State) Baltimore
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE JUN 5 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

equire

hours after death. Page 4

by the funeral director,
should be filed with

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6479

06463

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. 16, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3635 MARRIOTT LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First HOWARD Middle GORDON Last GRAHAM		4. DATE OF DEATH Month 6 Day 19 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 20, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 3 Days 1 Hours 1 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN - FALLS		10b. KIND OF BUSINESS OR INDUSTRY FOREMAN - FALLS	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? VISA-	

13. FATHER'S NAME ROBERT GRAHAM		14. MOTHER'S MAIDEN NAME ROSALIE ARMSTRONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-03-4965	
17. INFORMANT MRS. LILLIAN GRAHAM -		Address 3635 MARRIOTT LANE - 7	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS - 1st 2 YRS. AGO DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 YEARS DUE TO (c)		INTERVAL BETWEEN ONSET OF DISEASE AND DEATH 2 YEARS
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUGUST 10, 1959 to 6/19, 1961 , that (I) (we) last saw the deceased alive on 6/19, 1961 , and that death occurred at 12:30 PM from the causes and on the date stated above	
22a. SIGNATURE Edwin L. Pierpont	22b. DATE SIGNED 6/19/61
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.	22d. ADDRESS 8204 LIBERTY RD., BALTO 7, MD

23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-22-61	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	23d. LOCATION (City, town, or county) (State) Pikesville, Maryland
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24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tichner & Sons	25a. REC'D BY REGISTRAR June 21 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Harris
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that the death certificate be executed



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

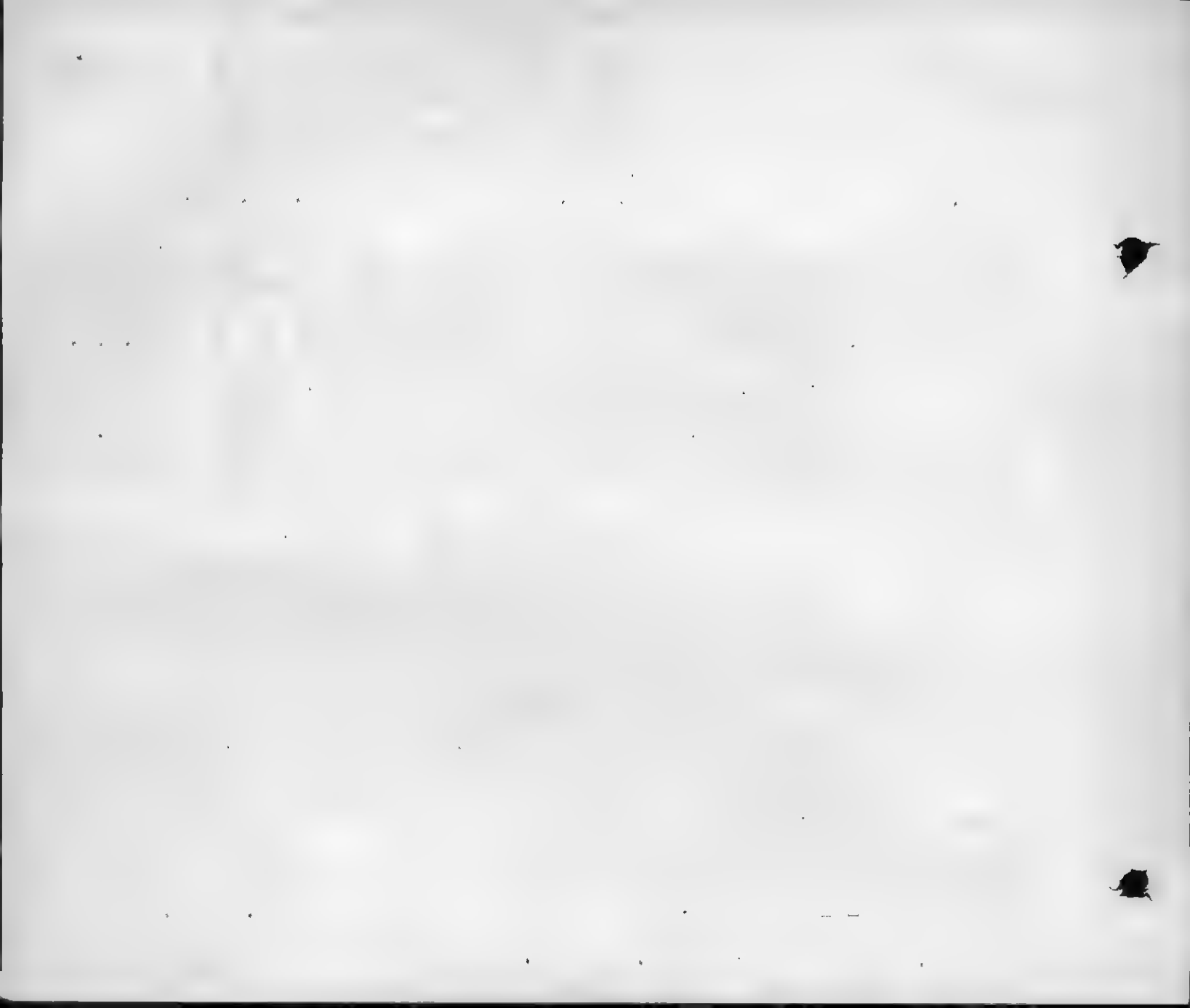
6480

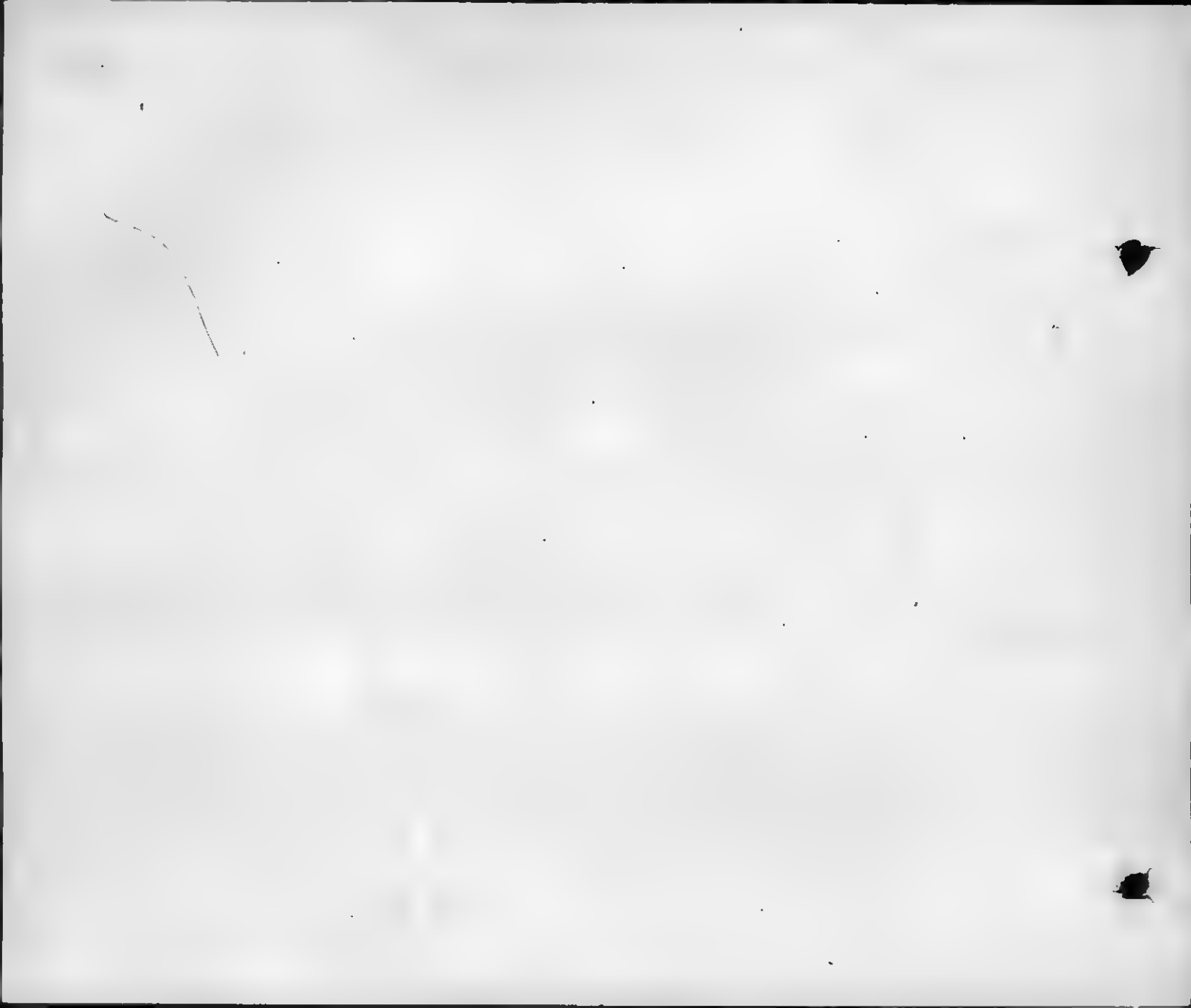
CERTIFICATE OF DEATH

Reg. Dist. No. 06464

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Res., 300 Pinewood Rd. 22, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Edward Gray</u>				4. DATE OF DEATH <u>June 4, 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1906</u>		9. AGE (In years last birthday) <u>55</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Crane Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Patapasco Scrap Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Gray</u>				14. MOTHER'S MAIDEN NAME <u>Barbara E. Dolan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>163-14-2393</u>		17. INFORMANT <u>Mrs. Pauline Gray</u> Address <u>300 Pinewood Rd. 22, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Generalized Calcinoses</u> DUE TO (c) <u>LUNG CANCER w/ eg. metastasis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Nov 1956</u> to <u>June 1961</u> , that I last saw the deceased alive on <u>June 4, 1961</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <u>Charles E. Gray</u> M.D.		DATE SIGNED <u>June 6-1961</u>					
PHYSICIAN'S NAME (Type) <u>Oswald Berrios MD</u>		<u>2903 West Woodwell Rd</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-7-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Ave. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u> ADDRESS <u>7922 Wise Ave. 22, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.





may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6482

06466

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) It. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION It. Wilson State Hospital				d. STREET ADDRESS 1236 W 37th St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last IRVING RANDOLPH GREEN				4. DATE OF DEATH Month Day Year 6 16 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-21-90	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINEMAN				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN R. GREEN				14. MOTHER'S MAIDEN NAME CHRISTIE F. BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO 217-01-5134		17. INFORMANT Address Hospital Records, It. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTASIS (GENERALIZED) 177X DUE TO (b) CARCINOMA OF PROSTATE Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 007X PULMONARY TUBERCULOSIS, SENILITY							
19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 12-1-1960 to 6-16-1961 , that (I) (we) last saw the deceased alive on 6-17-1961 , and that death occurred at 4:20 AM , from the causes and on the date stated above.							
22a. SIGNATURE W. Murcom				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 22	
22c. PHYSICIAN'S NAME (Type) W. Murcom, M.D. Superintendent				22d. ADDRESS It. Wilson State Hospital, It. Wilson, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/19/61		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City, town, or county) (State) Taylor Ave, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan				25a. REC'D BY REGISTRAR DATE JUN 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Francis	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C483

06467

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN 1b

99 Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF DECEASED

(Type or print)

First

ROY

Middle

(NMI)

GREEN

5 SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6/20/90

9. AGE (In years last birthday)

170 yrs.

4 DATE OF DEATH

Month

JUNE

Day

11

Year

19 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (County & State, or foreign country)

Ellaville, Georgia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Goad Green

14. MOTHER'S MAIDEN NAME

Katie Burden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

255-26-7205

17. INFORMANT

Clin. Rec. VAH, Balto. Md. Ft. Howard Division

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RUPTURED ESOPHAGEAL VARICES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

LAENNEC'S CIRRHOSIS

(c)

DUE TO

INTERVAL BETWEEN ONSET AND DEATH MINUTES

SEVERAL YEARS

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from March 4, 1961, to June 11, 1961, that (we) saw the deceased alive on June 11, 1961, and that death occurred at 6:30AM from the causes and on the date stated above.

22a. SIGNATURE

Joseph J. Cillo M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED

6/11/61

22c. PHYSICIAN'S NAME (Type)

JOSEPH J. CILLO, M.D.

VAH, BALTO. MD. FORT HOWARD DIVISION

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

6-15-61

23c. NAME OF CEMETERY OR CREMATORY

Baltimore National

23d. LOCATION (City, town or county)

Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

Arlington S. Phillips

ADDRESS

1808 N. Monroe St. Baltimore, Maryland

25a. REC'D BY REGISTRAR

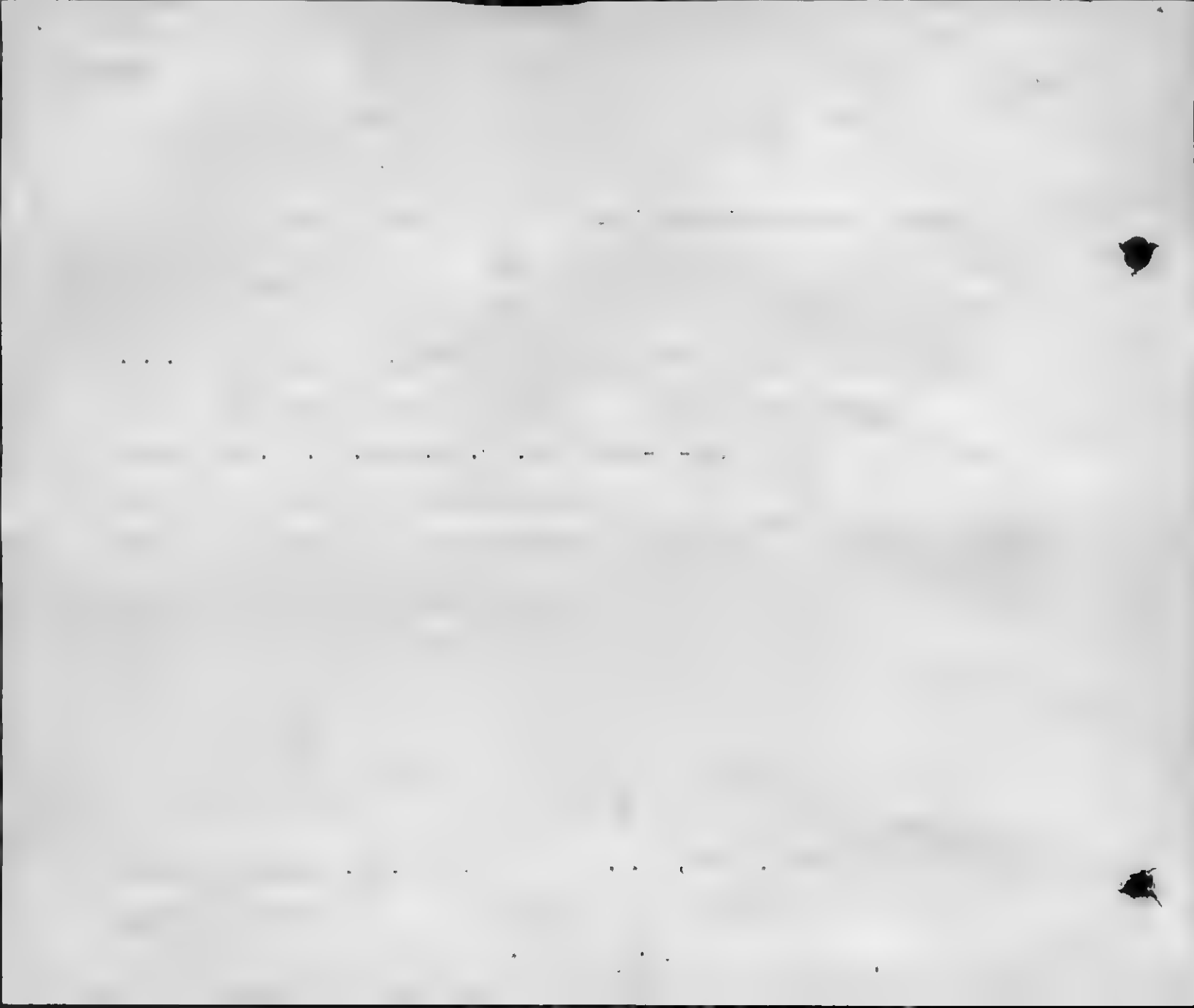
DATE JUN 14 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraw

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06468

6484

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>			e. STREET ADDRESS <u>7812 Wendover Avenue</u>		
3. NAME OF DECEASED (Type or print) First <u>Dale</u> Middle <u>Wayne</u> Last <u>Groth</u>			4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>19 61</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/60</u>		9. AGE (In years last birthday) Yrs. <u>11</u> Months <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John David Groth</u>		
14. MOTHER'S MAIDEN NAME <u>June Landonia Kerr</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT <u>Rosewood Records, Owings Mills, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marked Hydrocephalus</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>44.1</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., the causes and on the date stated above.					
22a. SIGNATURE <u>Peter W. Rieckert</u>		M.D. <u>Peter W. Rieckert</u>		22b. ADDRESS <u>4307 Mainfield Ave Baltimore</u>	
22c. PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		22d. ADDRESS <u>4307 Mainfield Ave Baltimore</u>		22e. DATE <u>JUN 13 '61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>	
23d. LOCATION (City, town or county) <u>Baltimore Md.</u>		(State)		23e. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
23f. REGISTRAR'S SIGNATURE <u>John C. Miller</u>		23g. ADDRESS <u>2431-35 E. Oliver St.</u>		23h. DATE <u>JUN 13 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2037303 XV4



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

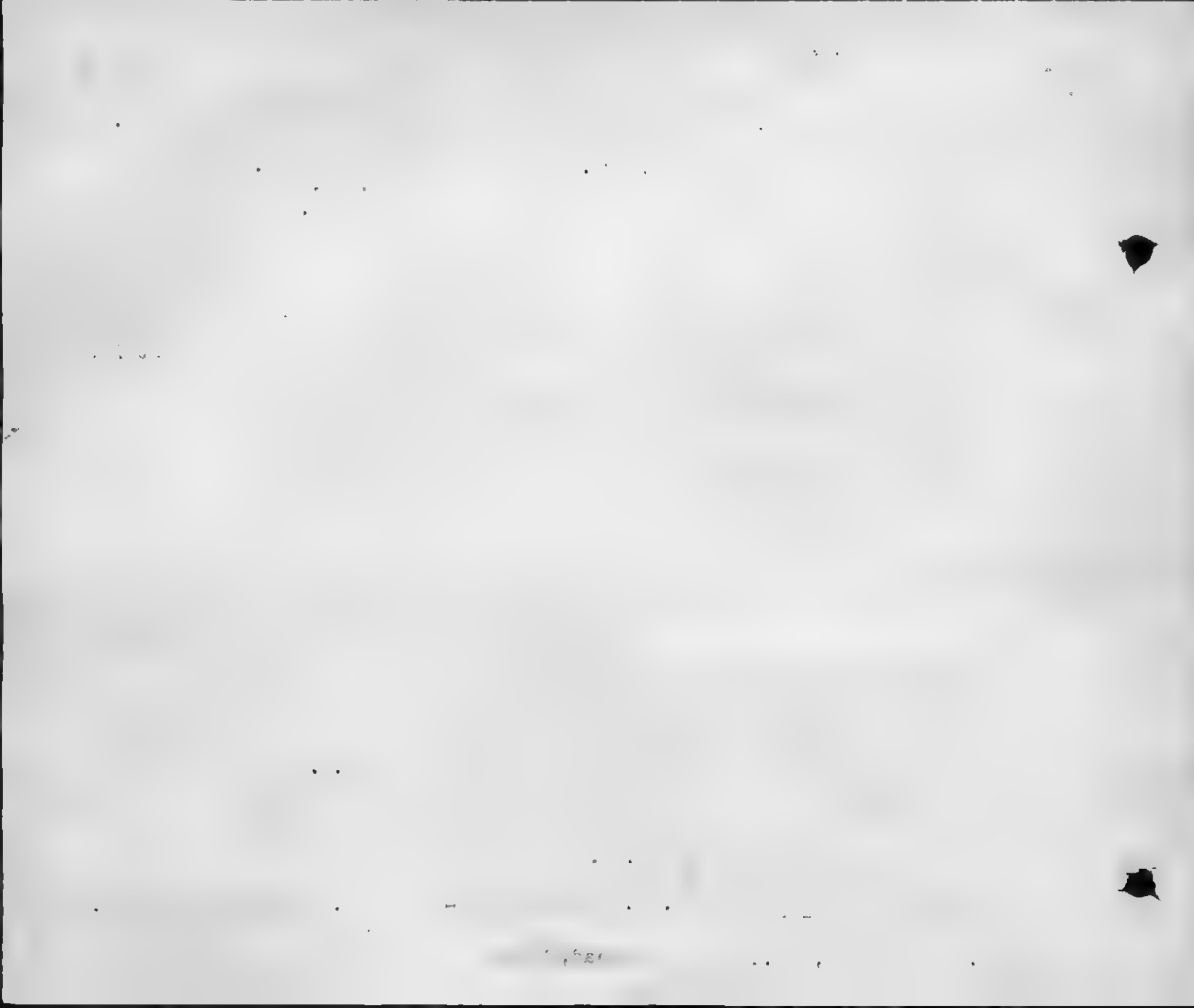
6485

CERTIFICATE OF DEATH

06469

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN <u>7 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stella Maris Hospice</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Mt. Washington</u> d. STREET ADDRESS <u>Mt. St. Agnes College</u> <u>5801 Smith Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rosie</u>		First Middle Last <u>Guercia</u>		4. DATE OF DEATH Month Day Year <u>6/29/ 19 61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/81 1887</u>	9. AGE (In years last birthday) <u>73 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>			
13. FATHER'S NAME <u>A ntonia Guercia</u>			14. MOTHER'S MAIDEN NAME <u>Conchetta</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>219-30-9199</u>		16. SOCIAL SECURITY NO. <u>219-30-9199</u>		17. INFORMANT <u>Admission Record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>260X</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>years?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>6/29 19 61</u> to <u>6/29 19 61</u> that (I) (we) last saw the deceased alive on <u>6/29 19 61</u> and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George Beck M. D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <u>6/29/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>George Beck M. D.</u>		22d. ADDRESS <u>6012 Harford Rd, Balto, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Agnes Convent cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Mt. Washington, Balto. Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook* Towson, Inc., 1050 York Road, Towson 4</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>JUL 3 61</u>	25b. REGISTRAR'S SIGNATURE <u>Charles S. Pinner</u>		

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06485

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06470

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6mth15days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>1352 Washington Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>V</u> Last <u>Hale</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>19 61</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1873</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown Caleb Bowdle</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Helen Barwick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>On 3-13-61 pt. fell to floor from chair sustaining a frac. of the left femur</u>					
20c. TIME OF INJURY Hour <u>7:15</u> P.M. Month, Day, Year <u>3-13 1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) <u>Catonsville 28, Maryland</u>		20g. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6-8-61</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6-12-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) <u>Abingdon</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassalle Funeral Home 7401 Selma Road</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Haines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

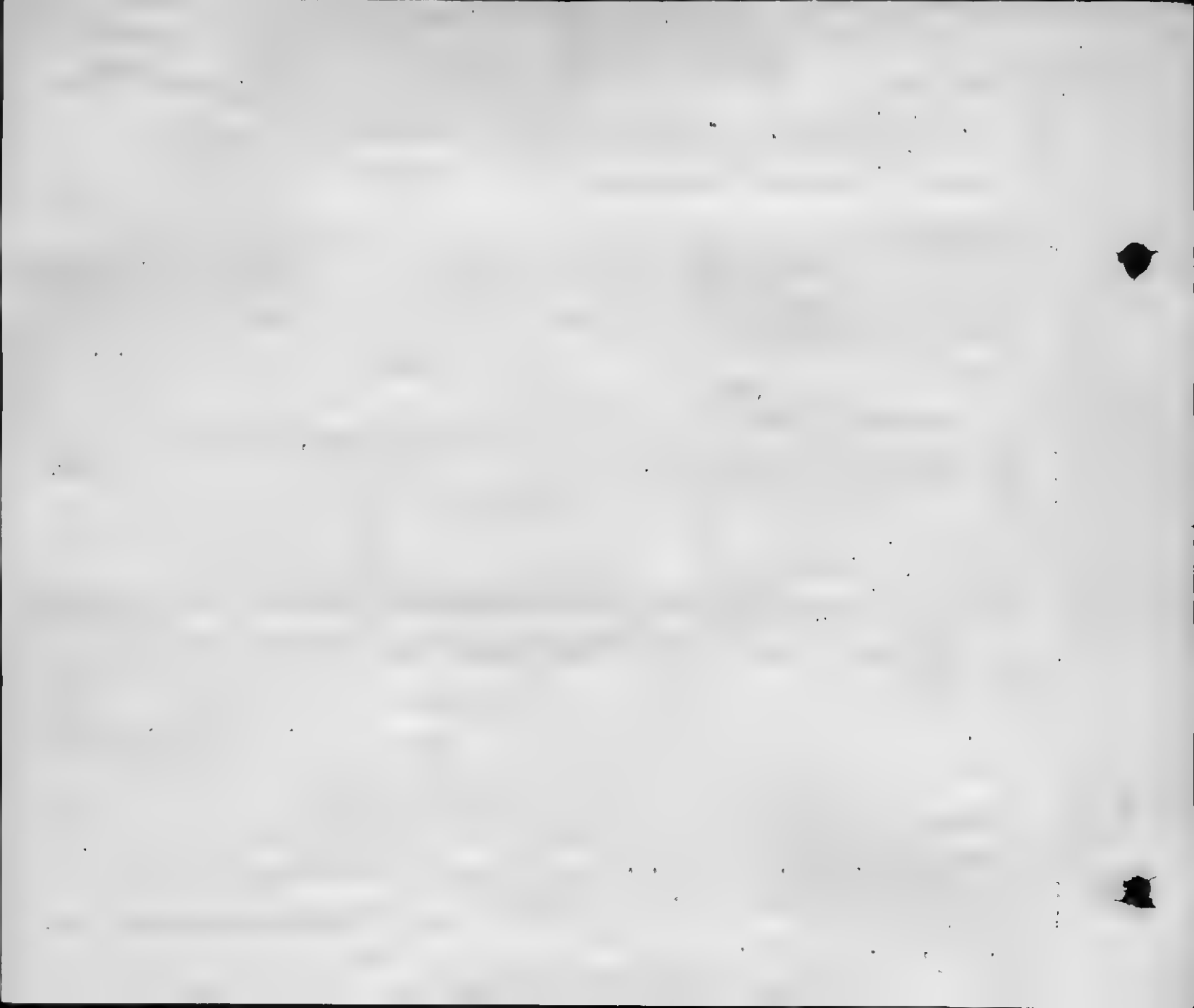


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ERNEST ERNEST HAMILTON		4. DATE OF DEATH Month June Day 4 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH unknown Age 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Reeves Hamilton		14. MOTHER'S MAIDEN NAME Alice Branhan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Cheaton Funeral Home, Lynchburg, Va		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head	
20c. TIME OF INJURY Month, Day, Year 6:20 p.m. 6/4/ 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods	20f. (City or town) (County) (State) Oella, Baltimore, Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		DATE SIGNED 6/5/61	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6-19-61	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Episcopal Mission Cemetery		22d. LOCATION (City, town, or country) (State) Amherst County, Virginia	
23. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street		24. REC'D BY REGISTRAR JUN 20 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Anthony S. Humes	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6488

CERTIFICATE OF DEATH

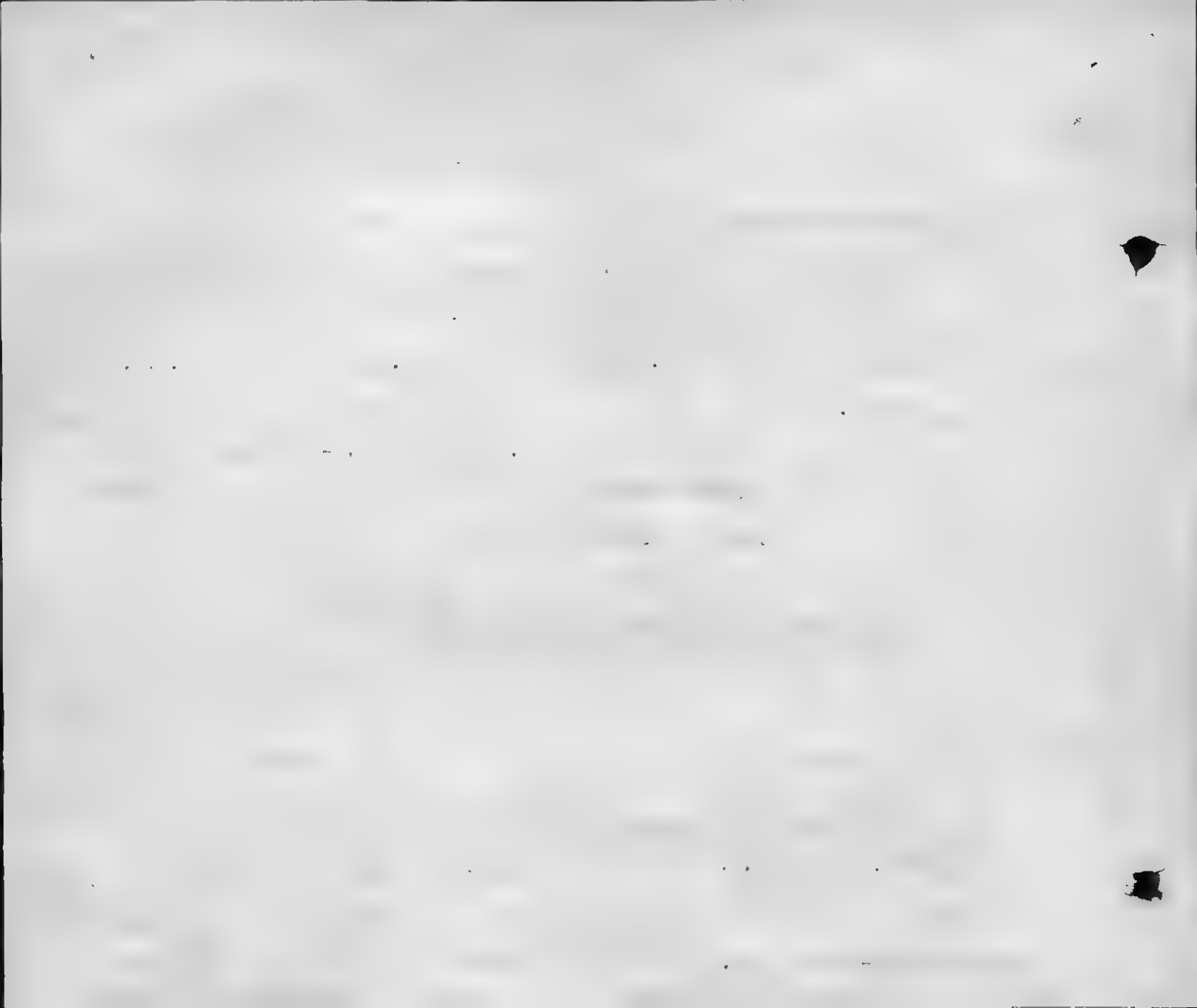
06472

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>34 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore -6</u> d. STREET ADDRESS <u>8533 Philadelphia Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGE R. HAMMER</u>				4. DATE OF DEATH <u>June 8 1961</u>			
5. SEX <u>Male</u> b. COLOR OR RACE <u>White</u> 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <u>July 30, 1895</u> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u> Hours <u>61</u> Min.				8. DATE OF BIRTH <u>July 30, 1895</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph G. Hammer</u>				14. MOTHER'S MAIDEN NAME <u>Ella Jane Beeks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW-1</u> 16. SOCIAL SECURITY NO <u>215-05-5216</u>				17. INFORMANT <u>Clinical Folders</u> Address <u>3900 Loch Raven Blvd. Balto 18, Md. -FORT HOWARD DIVISION</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) <u>PORTAL CIRRHOSIS OF LIVER</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE -Duration Unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u> <u>UNKNOWN</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY: Hour <u>19</u> e.m. Month, Day, Year <u>June 8 1961</u> 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.): <u>VAH, Fort Howard, Maryland</u> 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>May 5 1961</u> to <u>June 8 1961</u> that (I) (we) last saw the deceased alive on <u>June 8 1961</u> and that death occurred at <u>3:16 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Thomas F. Crahan</u> 22b. DATE SIGNED <u>6/9/61</u> 22c. NAME OF PHYSICIAN <u>THOMAS F. CRAHAN, M.D.</u> 22d. ADDRESS <u>VAH, Fort Howard, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/12/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook-Blight, Inc.</u> 25a. REC'D BY REGISTRAR <u>William S. Kraus</u> ADDRESS <u>6009 Harford Road Baltimore, Maryland</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u> DATE <u>JUN 12 '61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

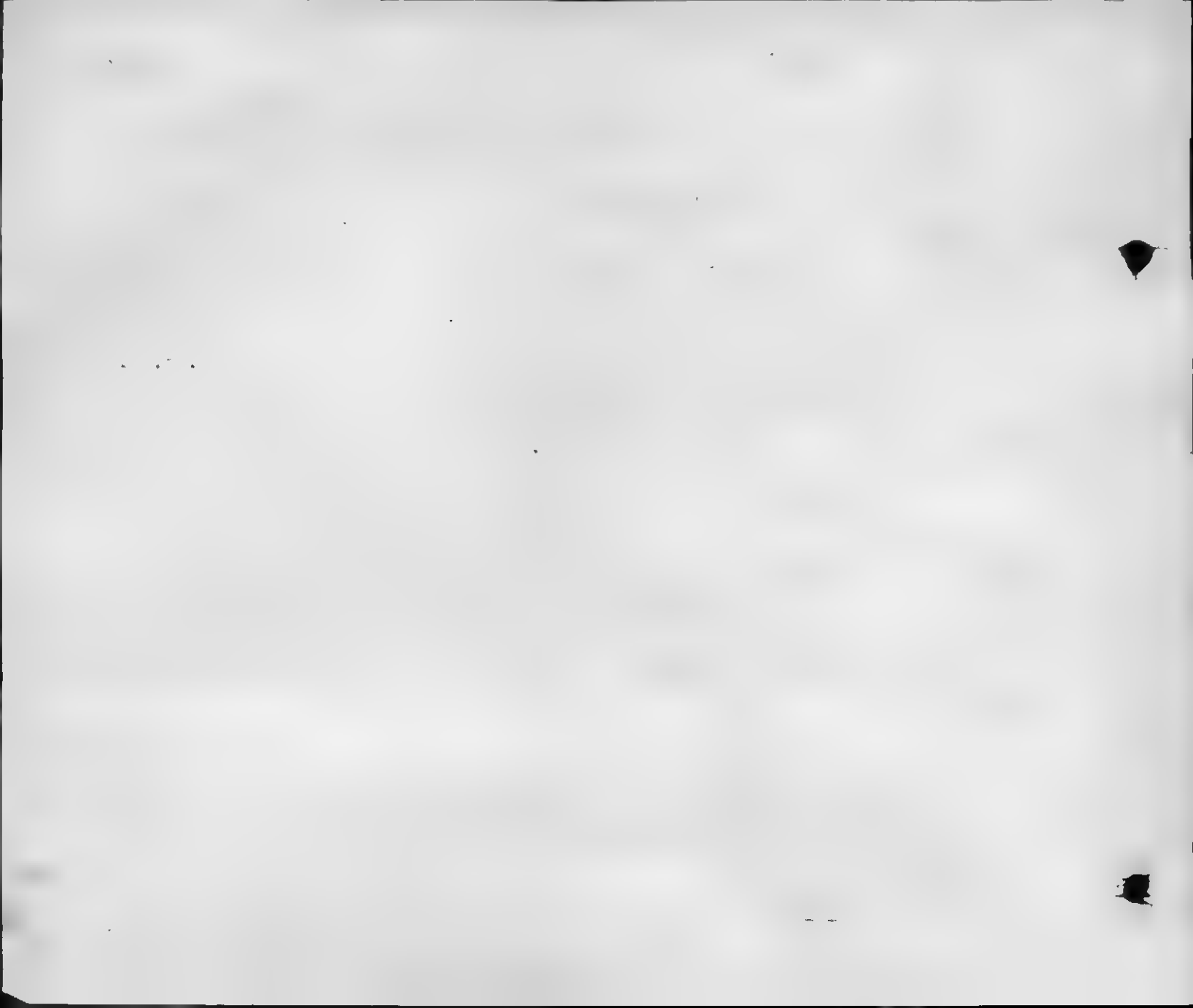
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6483

06473

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY N 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>315 Ingleside Avenue</u> <u>Forest Haven Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore County</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Formerly of Towson, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Martha Susan Hardesty</u>		4. DATE OF DEATH <u>June 29, 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1871</u>	9. AGE (in years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>James Keiningham</u>		14. MOTHER'S MAIDEN NAME <u>Lucy ?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. Robert Rector-400 Hopkins Road</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> DUE TO <u>CEREBRAL VASCULAR ACCIDENT</u> <u> </u> DUE TO <u>CARDIOSCLEROTIC HYPERTENSION</u> <u> </u> DUE TO <u>PULMONARY EDEMA - PNEUMONIA</u> <u> </u> DUE TO <u>DIPHTHERIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u> </u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>		
20c. TIME OF INJURY Month. Day. Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>6/1/61</u> to <u>6/29/61</u> , that (I) (we) last saw the deceased alive on <u>6/29/61</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>John A. Shaw M.D.</u>		22b. DATE SIGNED <u>6/30/61</u>	22c. PHYSICIAN'S NAME (Type) <u>John A. Shaw M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>	(State) <u> </u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Zickert</u>		25a. REC'D BY REGISTRAR <u>Jul 3 '61</u>	25b. REGISTRAR'S SIGNATURE <u>William S. Hunt</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

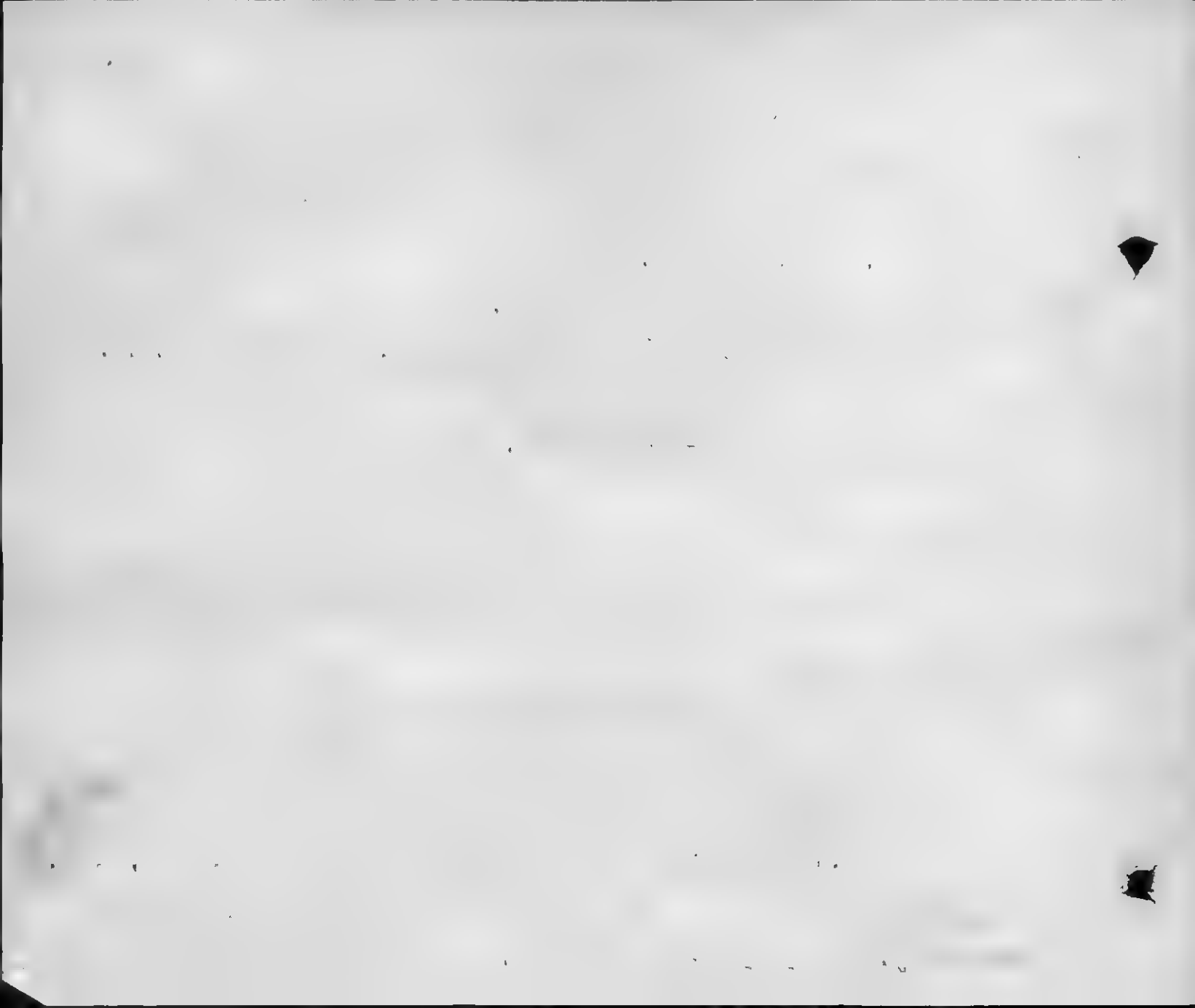
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06474

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5302 Mc Cormick Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5302 Mc Cormick Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. William James Harps</u>		4. DATE OF DEATH <u>June 29th 1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17, 1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armco Steel Co</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>212-08-7072</u>	
17. INFORMANT <u>Mrs. Josephine Harps</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> 163X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cancer of the lungs</u> } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Few days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-29-1961</u> to <u>6-29-1961</u> , that (I) (we) last saw the deceased alive on <u>6-29-1961</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr John Geldrich</u>		22b. DATE SIGNED <u>6-29-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John Geldrich</u>		22d. ADDRESS <u>8019 Philadelphia Road, Balto. 6, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial 7-1-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		23e. REC'D BY REGISTRAR <u>JUL 3 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
ADDRESS <u>5305 Harford Road #14</u>		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06475											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE c. LENGTH OF STAY IN 1b 5 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MASONIC HOME						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY --- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 115 E. MELROSE AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOLA M HAYDEN						4. DATE OF DEATH JUNE 30 1961					
5. SEX FE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-5-1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME GEORGE MEREDITH						14. MOTHER'S MAIDEN NAME MARY TARMAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-28-5118		17. INFORMANT J. & K. Smith Address Cockeysville, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: LEAD DUE TO Anterior Acute Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO --- DUE TO --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ---										INTERVAL BETWEEN ONSET AND DEATH 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2-7 , 1961, to 6-30 , 1961, that (I) (we) last saw the deceased alive on 6-30 , 1961, and that death occurred at 5:58 P.M., from the causes and on the date stated above.											
22a. SIGNATURE Walter T. Kees M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/30/61			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES						22d. ADDRESS COCKEYSVILLE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		July 3, 1961		Druid Ridge		Baltimore, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St. ADDRESS						25a. REC'D BY REGISTRAR JUL 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

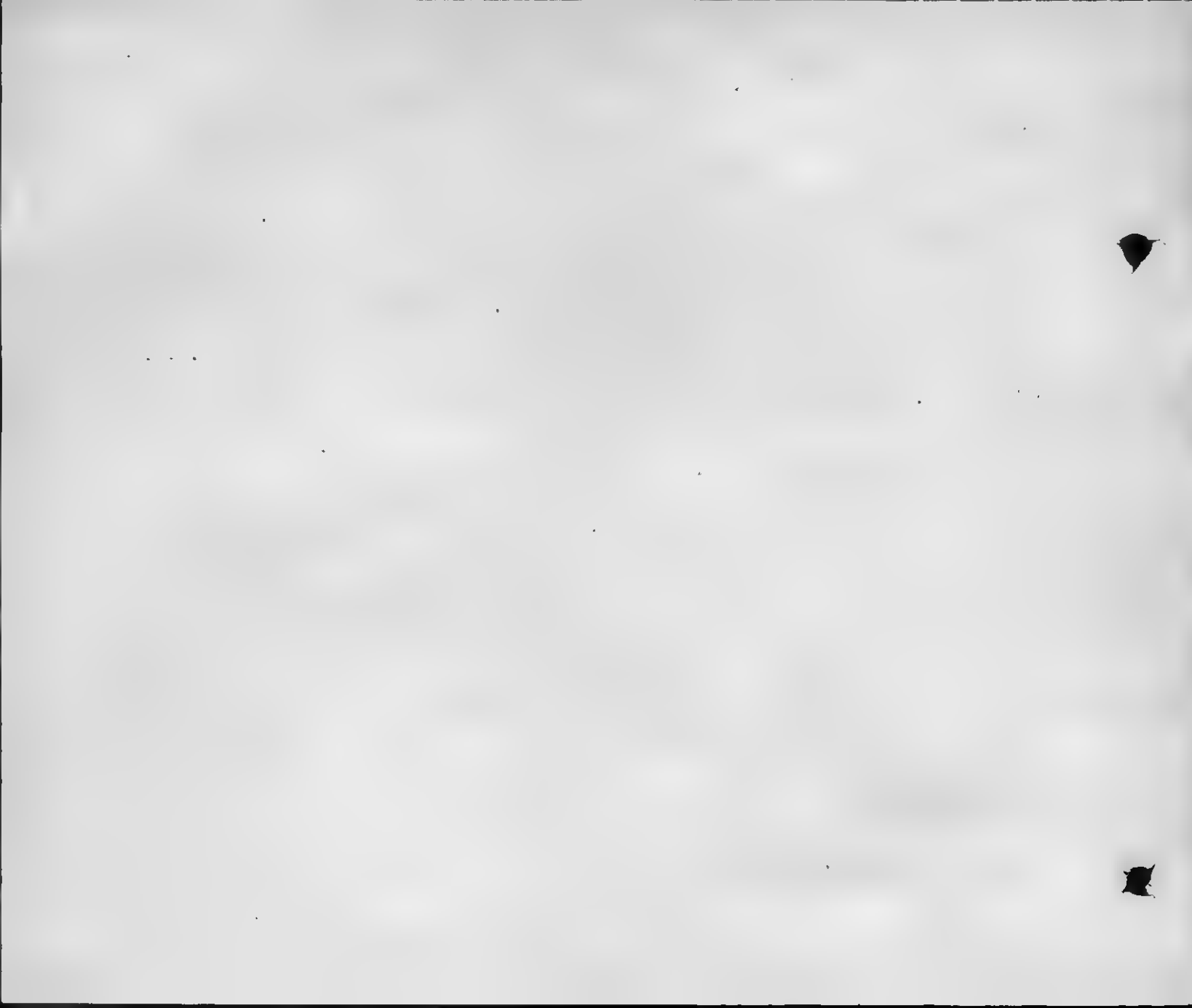
6492

06476

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in the Pines Nursing Home</u> <u>16 Fisting Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Oaklee Village Apt. 15 # 29</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Frederick Heiner</u>		4. DATE OF DEATH <u>June 4, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Butler Brothers</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Heiner</u>		14. MOTHER'S MAIDEN NAME <u>Fredericka Mahr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Miss Etta Heiner-Apt. 15 Oaklee Village</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis - Pneumonia</u> (b) <u>Generalized Arteriosclerosis Cardiovascular</u> (c) <u>6/2/61 10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , to <u>6/14</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/4</u> , 19 <u>61</u> , and that death occurred at <u>8:20</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph G. Laukaitis</u> M.D.		22b. DATE SIGNED <u>6/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph G. Laukaitis</u>		22d. ADDRESS <u>679 Washington Boulevard</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hor J. Zickner & Son</u>		25a. REC'D BY REG STRAR <u>North Penna Ave</u> DATE <u>JUN 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm L. Thomas</u>			

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

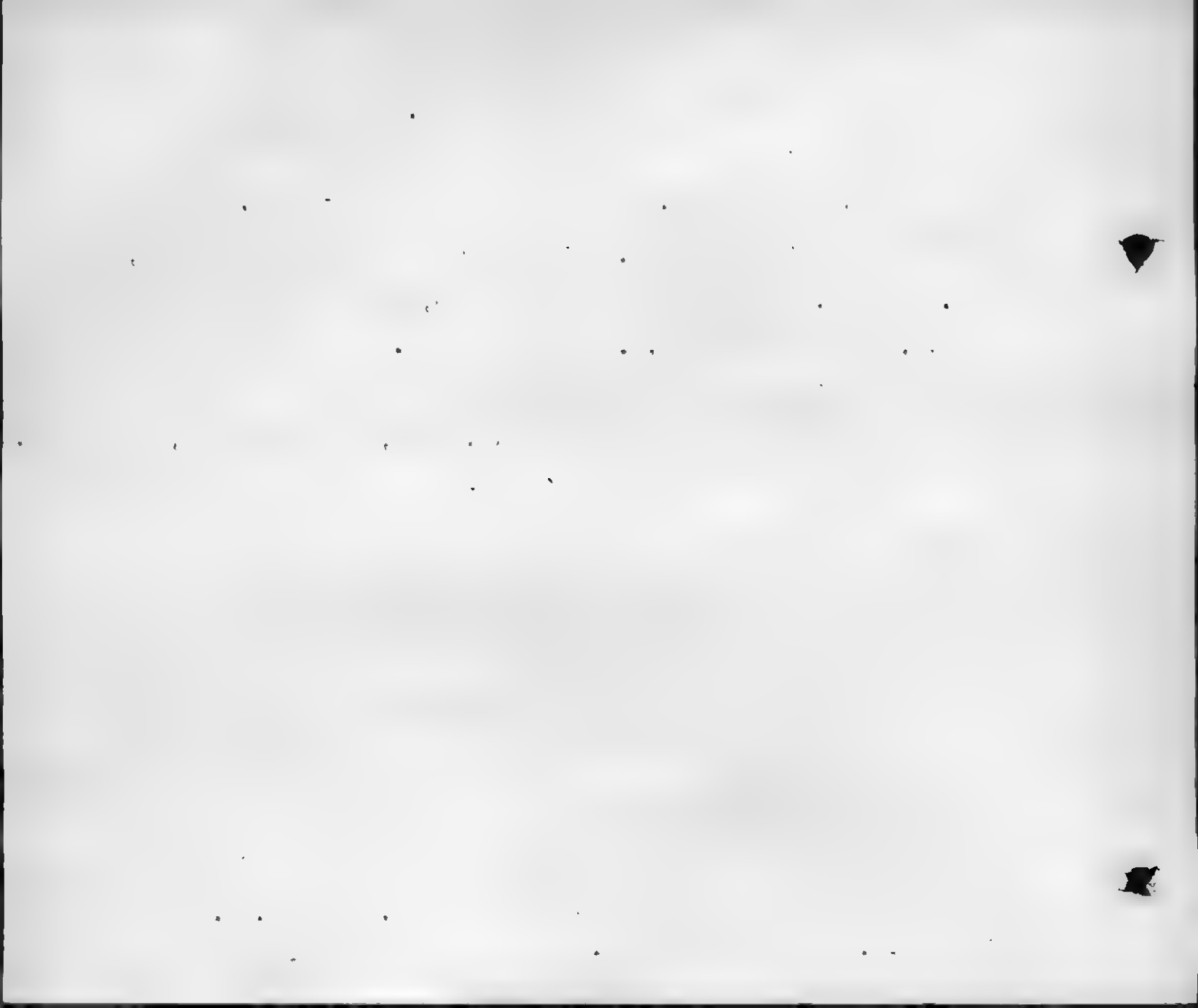
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6493

06477

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Josephs Nurs. Home		d. STREET ADDRESS 3065 Strickland St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle E. Heimmuller Last		4. DATE OF DEATH Month June Day 16 Year 1961	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1871
9. AGE (in years last birthday) 89 yrs.		10. IF UNDER 1 YEAR: Months 2 Days 4 Hours 32 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME O'Brien		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Address Mrs G.R. Flatt, 10 Boone Trail, Severna Pk.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 154X DUE TO CA of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. with metastases to liver (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 4 32	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-1-61 , 19 61 , to 6-16 , 19 61 , that (I) (we) last saw the deceased alive on 6-16 , 19 61 , and that death occurred at 7P M, from the causes and on the date stated above.			
22a. SIGNATURE James E. Howell		22b. DATE SIGNED 6-17-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Catonville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/19/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cmty.		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Witzke F.D. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE JUN 20 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. House	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

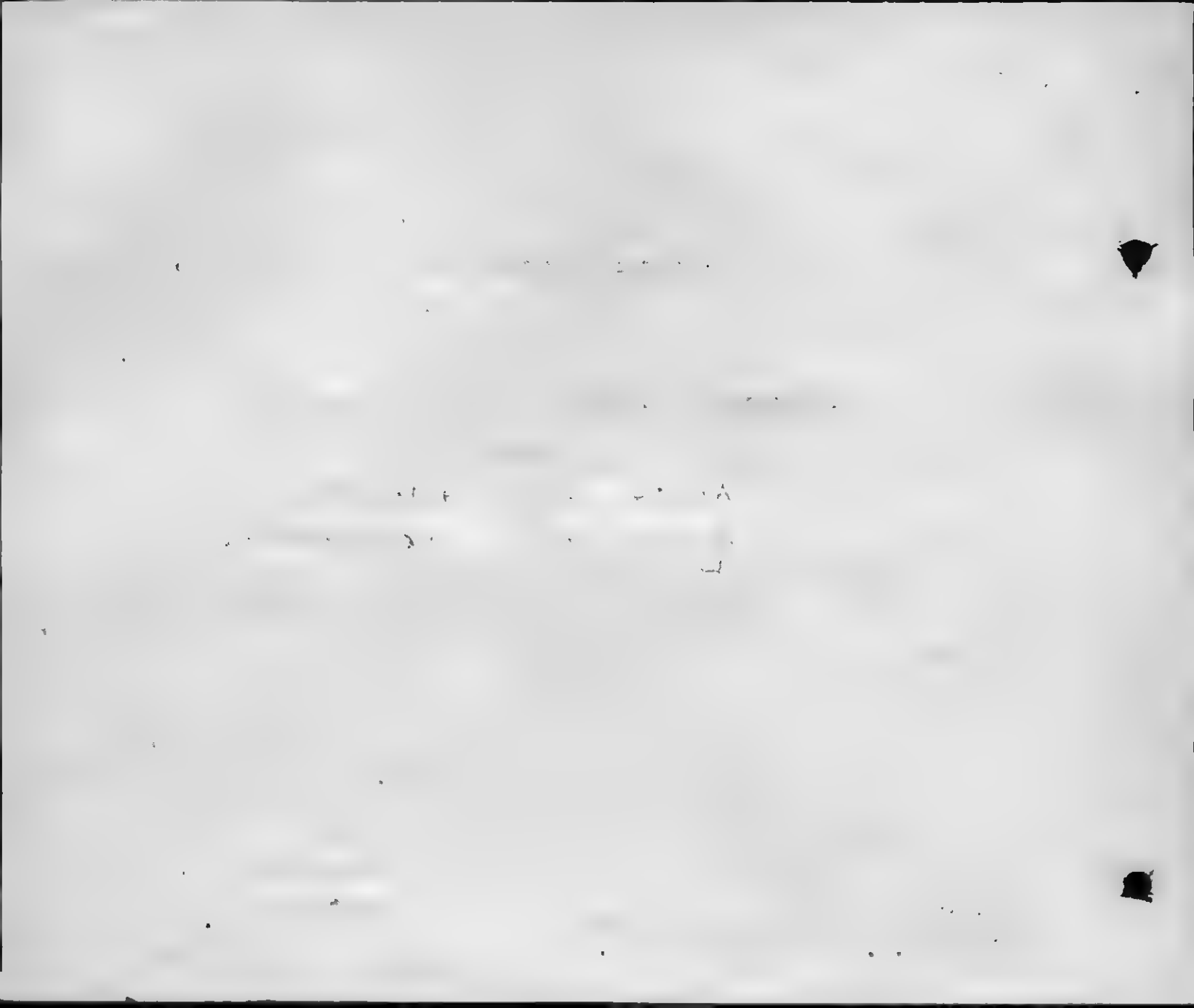
6494

06478

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>6yr3mthldy</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>535 S. Fulton Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Fred Heinzenberger</u> Heinzenberger First Middle Last				4. DATE OF DEATH <u>June 23, 1961</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August 24, 1885</u>			
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ba ker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Conrad Heinzenberger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Heinzenberger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <u>June 23, 1961</u> to <u>June 23, 1961</u> , that (we) last saw the deceased alive on <u>June 23, 1961</u> , and that death occurred at <u>10pm</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jose R. Arizaga</u> M.D.				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western</u>			
23d. LOCATION (City, town or county) <u>Baltimore Md.</u>		23e. REC'D BY REGISTRAR <u>DA JUN 26 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F.D. 4101 Edmondson Ave.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

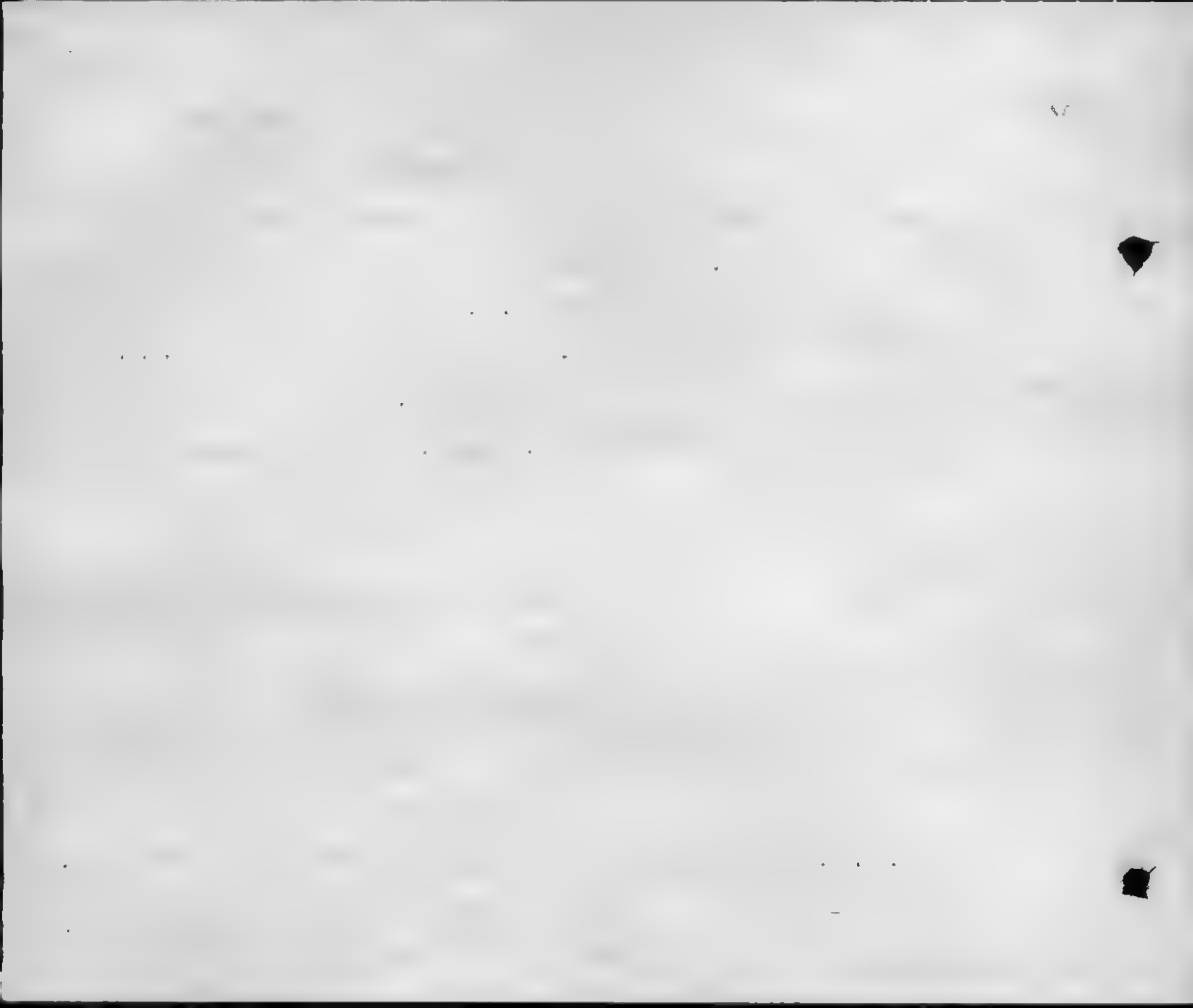
VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 11/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
6495 CERTIFICATE OF DEATH			
06479			
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Catonsville Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS 2012 Whittier Avenue	
3. NAME OF DECEASED (Type or print) Le Roy F. Hendricks		4. DATE OF DEATH June 17, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1885	
9. AGE (In years last birthday) 75 yrs.		10. AGE (In years last birthday) 75 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Eli Hendricks	
14. MOTHER'S MAIDEN NAME Harriet S. Flock		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	
16. SOCIAL SECURITY NO. 213-26-1801		17. INFORMANT Mrs. Edith B. Mc Clure-729 Cator Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 16, 1961 , to June 17, 1961 , that (I) (we) last saw the deceased alive on June 16, 1961 , and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. D. C. Mac Laughlin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. D. C. Mac Laughlin		22d. ADDRESS 4508 Edmondson Avenue Baltimore, Md.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 16-20-61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City, town or county) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckers & Sons	
25a. REC'D BY REGISTRAR Wm. J. Tuckers & Sons		25b. REGISTRAR'S SIGNATURE Wm. J. Tuckers & Sons	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6496

CERTIFICATE OF DEATH

Reg. Dist. No. 06480

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>20141</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Home</u>		e. STREET ADDRESS <u>1911 Rockwell Ave</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>HICKMAN</u> Middle <u>HICKMAN</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FUNERAL-BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE W. HICKMAN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. MORGAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. HERBERT S. HICKMAN</u>		18. ADDRESS (Street, city or town, state) <u>2107 Meadmont Drive (7)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR Occlusion.</u> 22X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic changes.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6/24/61 - 10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1960</u> , to <u>June 29</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>61</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>6-30-61</u>	
PHYSICIAN'S NAME (Type) <u>G. Truman Schwab</u>		M.D. <u>6014 Elmwood Ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/3/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Truman Schwab</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
ISM 9/60

AP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6497 CERTIFICATE OF DEATH 06481											
Items 21 & 22 Film 6-89 6/27/61 ink											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8705 Emge Road</u>				d. STREET ADDRESS <u>8705 Emge Road</u>				a. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u>		First <u>John</u> Middle <u>J.</u> Last <u>Hiebler</u>		4. DATE OF DEATH <u>June 18th</u> 19 <u>61</u>		Month <u>June</u> Day <u>18th</u> Year <u>19 61</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 19, 1887</u>		9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Hiebler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reisin</u>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>218-18-5358</u>				17. INFORMANT <u>Mrs. Ella M. Hiebler</u> Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic CVD</u> (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>1-18, 1961</u> to <u>6-18, 1961</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>6/14, 1961</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph F. Lippa</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph F. Lippa</u>				22d. ADDRESS <u>4400 Loch Raven Blvd Baltimore, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR <u>JUN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

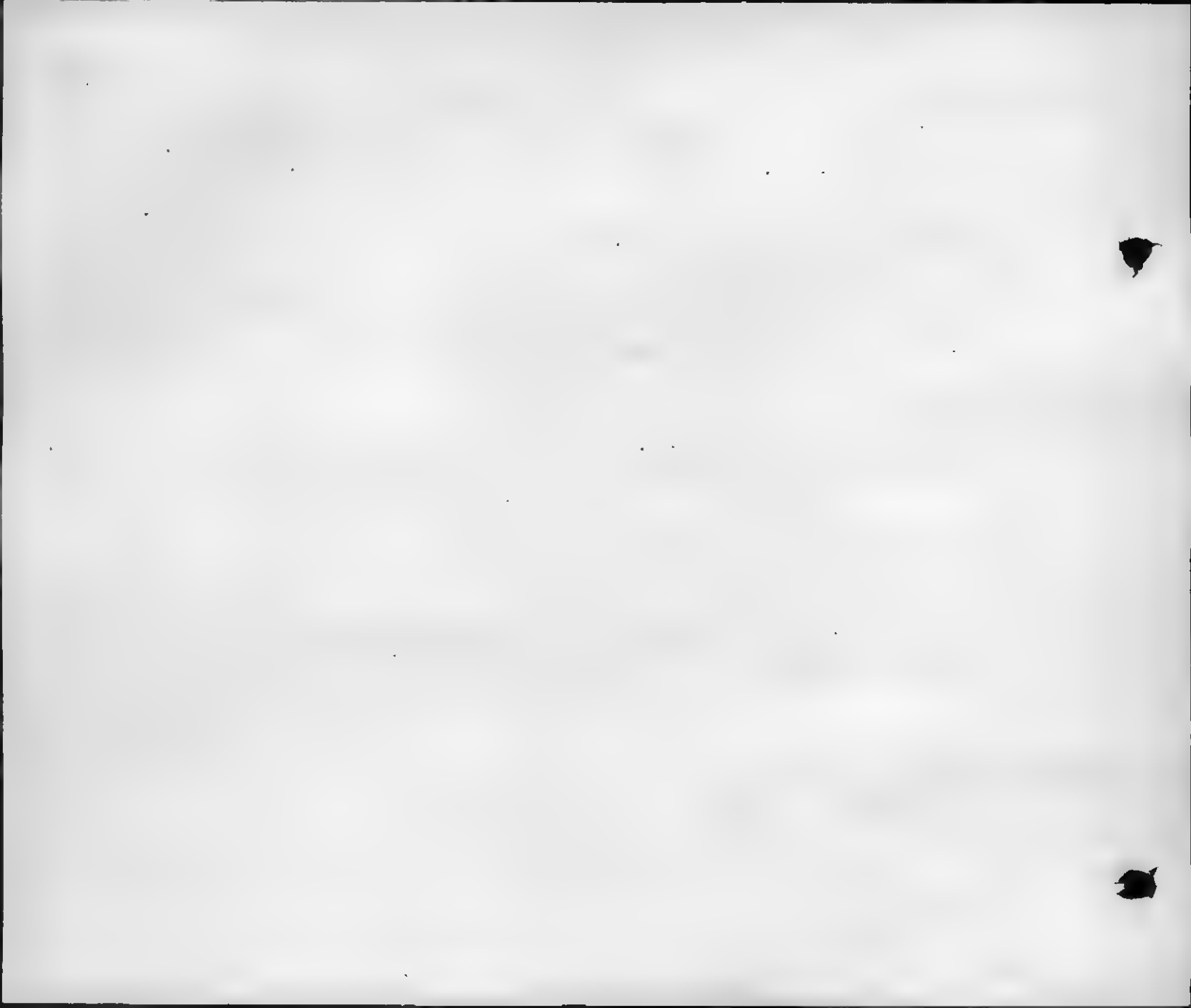
VR A15 (4)
15M 9/59

6498

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06482

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Md.		c. LENGTH OF STAY IN 1b 5/7/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Md. (formerly Balto City)	
		d. STREET ADDRESS 329 Harlem Lane (411 Nelson St.)	
3. NAME OF DECEASED (Type or print) First Lieu (also Luh Ham) Middle HIM Last MIN		4. DATE OF DEATH Month 6 Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE Yellow CHINA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Robert Lew		Address White Rice Inn Park Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arterio sclerosis DUE TO (c) Hypertensive heart disease		INTERVAL BETWEEN ONSET AND DEATH Immediate Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary insufficiency - last 2 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 7 19 57 to June 23 19 61 , that (I) (we) last saw the deceased alive on June 21 19 61 , and that death occurred at 12:25 M, from the causes and on the date stated above			
22a. SIGNATURE Cliff Ratliff, Jr. M.D.		22b. DATE 6/23/61	
22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.		22d. ADDRESS 4605 EDMONDSON AVE #29	
23a. BURIAL, CREMATION, or REMOVAL (Specify) burial June 26/61		23b. NAME OF CEMETERY OR CREMATORY Lawrence Woodlawn	
23c. LOCATION (City, town, or county) (State) New York - Balto.		23d. REC'D BY REGISTRAR JUN 26 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Stewart Moore		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Filed 6/10/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 06483

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23yrlmth26dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
		d. STREET ADDRESS 230 W. Durham Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Hobby Last		4. DATE OF DEATH Month June Day 7 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1901
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Shanks		14. MOTHER'S MAIDEN NAME Julia Shanks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis			
DUE TO Coronary Insufficiency			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1961 , to June 7, 1961 , that I last saw the deceased alive on June 7, 1961 , and that death occurred at 2:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Loretta Hsu		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-8-61	
PHYSICIAN'S NAME (Type) Loretta Hsu, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 6/15/61	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion, August	22d. LOCATION (City, town, or county) (State) Mt. Zion, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. McKee Funeral Home - Augusta, W. Va.		24a. REC'D BY REGISTRAR DATE JUN 9 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hsu	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. IF FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH

RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06484

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3224 Putty Hill Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>3224 Putty Hill Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Hubbard</u> Last <u>Sr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. tug Boat Capt.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>Rose Fitzpatrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Margaret C. Kunkel</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AT her selection Cardiovascular Disease</u> 722.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u> EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-12-67</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6-14-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or country) <u>Baltimore, Md.</u> (State)
23. FUNERAL DIRECTOR <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 13 '67</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



06485

6504

VR A15 (4)
15M 9/60

25b. REGISTRAR'S SIGNATURE
Arthur S. Krane

Dr. D. D. Copley
Deputy Co. Med. Exam.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

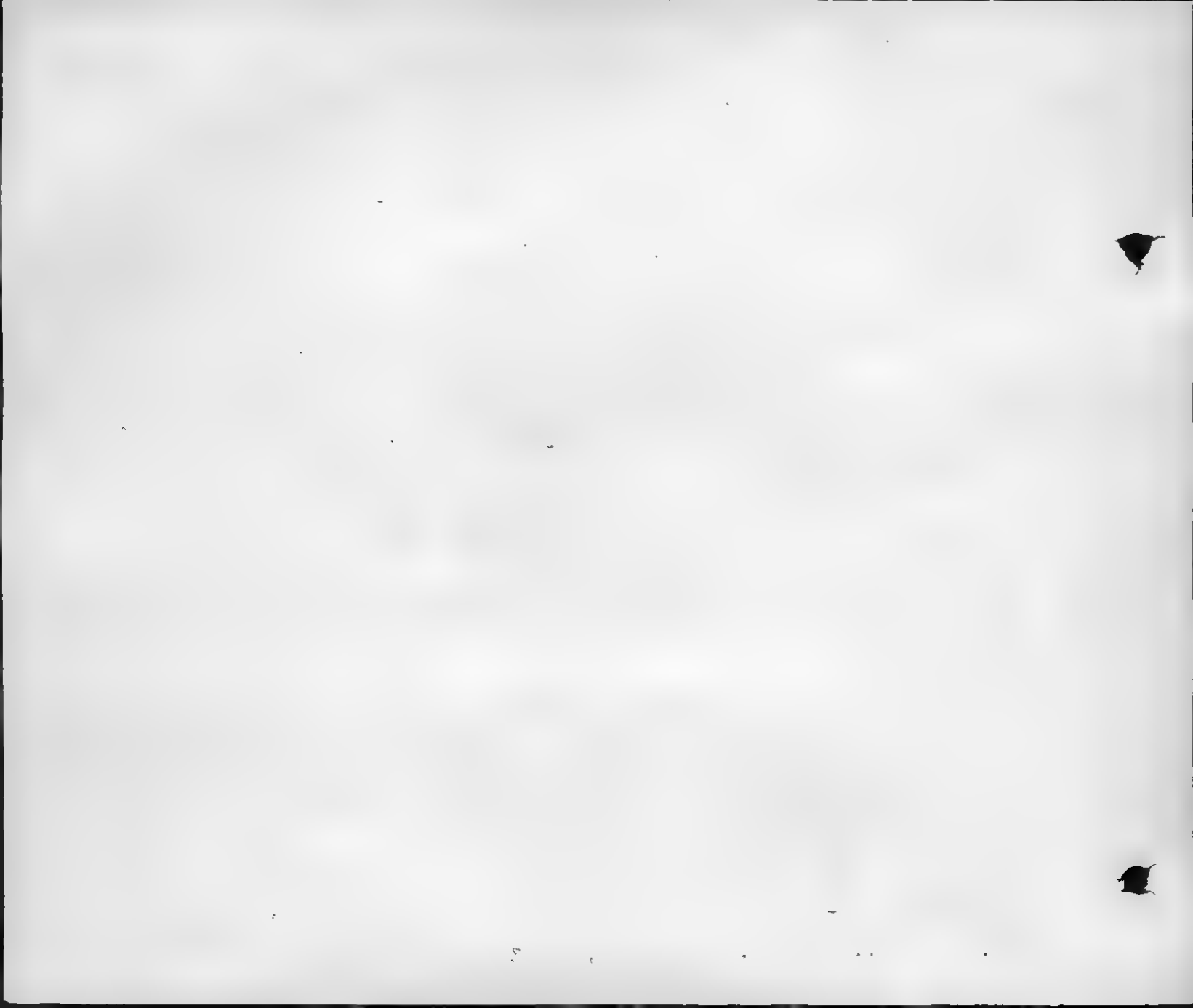
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6502

06486

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 3 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				e. STREET ADDRESS 1900 CHELSEA RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE GRAY JONES				4. DATE OF DEATH Month Day Year JUNE 25 1961			
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 12, 1891	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME WILLIAM A GRAY				14. MOTHER'S MAIDEN NAME MARY JANE WIDGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT Frank E. Smith		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Accident 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral & Generalized Arterio Sclerosis DUE TO 3 1/2 years (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-22 , 19 57 , to 6-25 , 19 61 , that (I) (we) last saw the deceased alive on 6-24 1961 , and that death occurred at 1 AM , from the causes and on the date stated above							
22a. SIGNATURE Walter T. Kees		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6/25/61			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-27-61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2				25a. REC'D BY REGISTRAR DATE JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6503

CERTIFICATE OF DEATH

Reg. Dist. No. 06487

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Overlea</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4704 Meise Dr.</u>		d. STREET ADDRESS <u>4704 Meise Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Stephen Paul KACEN</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1915</u>
9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tech. Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martin's</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13 FATHER'S NAME <u>Stephen ?</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>		16 SOCIAL SECURITY NO. <u>152-10-5736</u>	
INFORMANT <u>Kathleen Edith Kacen</u>		Address <u>4704 Meise Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> 19 <u>61</u> , to <u>June</u> 19 <u>61</u> , that I last saw the deceased alive on <u>6/17</u> 19 <u>61</u> , and that death occurred at <u>3:44</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Clark Holmes</u>		ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd. #4</u>	
PHYSICIAN'S NAME (Type) <u>A. Clark Holmes</u>		DATE SIGNED <u>6/22/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-24-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenlake Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bloomfield, New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cuch</u>		ADDRESS <u>1211 Chosco Ave.</u>	
24a. REC'D BY REGISTRAR <u>JUN 26 61</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

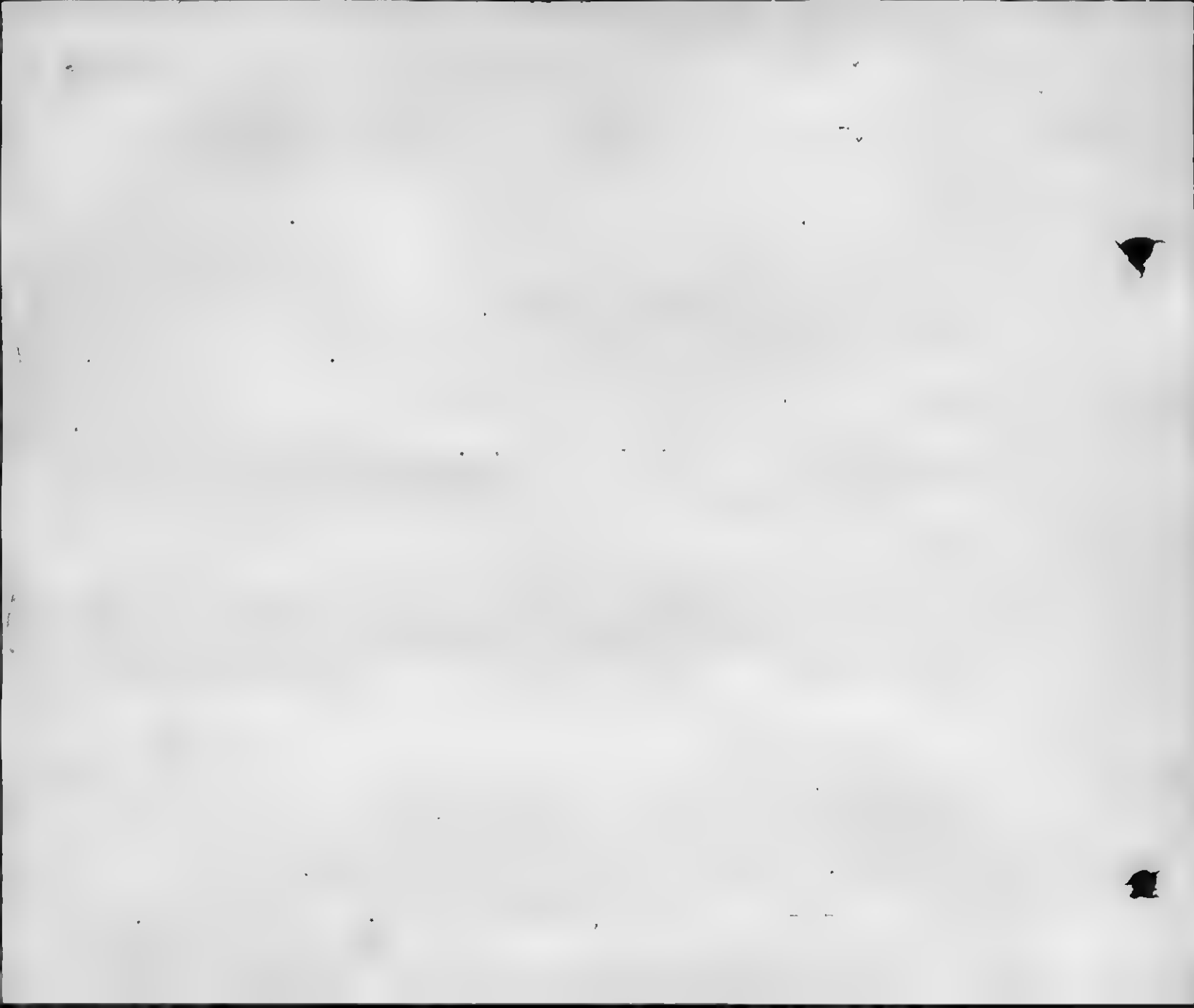
VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6504											
06488											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX				6. COLOR OR RACE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
8. DATE OF BIRTH				9. AGE (In years last birthday)				10. IF UNDER 1 YEAR Months Days			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				21. I certify that (I) (this hospital) attended the deceased from ... 6/12 ... 1961, to ... 6/15 ... 1961, that (I) (we) last saw the deceased alive ... 6/15 ... 1961, and that death occurred at ... M, from the causes and on the date stated above.			
22a. SIGNATURE				22b. DATE SIGNED				23a. NAME OF CEMETERY OR CREMATORY			
23b. DATE THEREOF				23c. LOCATION (City, town or county)				23d. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE				24a. ADDRESS				24b. REGISTRAR'S SIGNATURE			
24c. DATE				24d. REGISTRAR'S SIGNATURE				24e. DATE			

Retired homemaker
Nicholas Weller
Susetta ?
Mr. G. Donald Kammer, 1306 Breezy Lane N.E., Atlanta 6, Ga.
acute myocardial infarction
Carcinoma Colon
Leonard H. Colombek
Burial
6-15-61
London Park Baltimore, Md.
Wm. J. Tiebner & Sons, Baltimore, Md.
JUN 19 '61
Arthur S. Kraus



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6505

06489

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKTON				c. LENGTH OF STAY IN 1b PARKTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MT. CARMEL RD				d. STREET ADDRESS MT. CARMEL RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES A- Keil				4. DATE OF DEATH Month Day Year June 9 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY-28, 1878	9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY SEWING FACTORY		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HERMAN H. KEIL				14. MOTHER'S MAIDEN NAME DIEGLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-01-272			
17. INFORMANT ANNETTA K. MAYO - MT. CARMEL RD				Address PARKTON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertension (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Generalized Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1961 to June 9 1961 , that (I) (we) lost the deceased on June 9 1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE G. M. France M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/9/61	
22c. PHYSICIAN'S NAME (Type) A. M. FRANCE				22d. ADDRESS PARKTON, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-12-61		23c. NAME OF CEMETERY OR CREMATORY MORELAND PK		23d. LOCATION (City, town, or county) (State) TAYLOR AVE - BALTO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE W. M. Cook-Tolson - YORK RD - TOLSON - 4 MD				ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 12 '61	
				25b. REGISTRAR'S SIGNATURE William S. Hume			

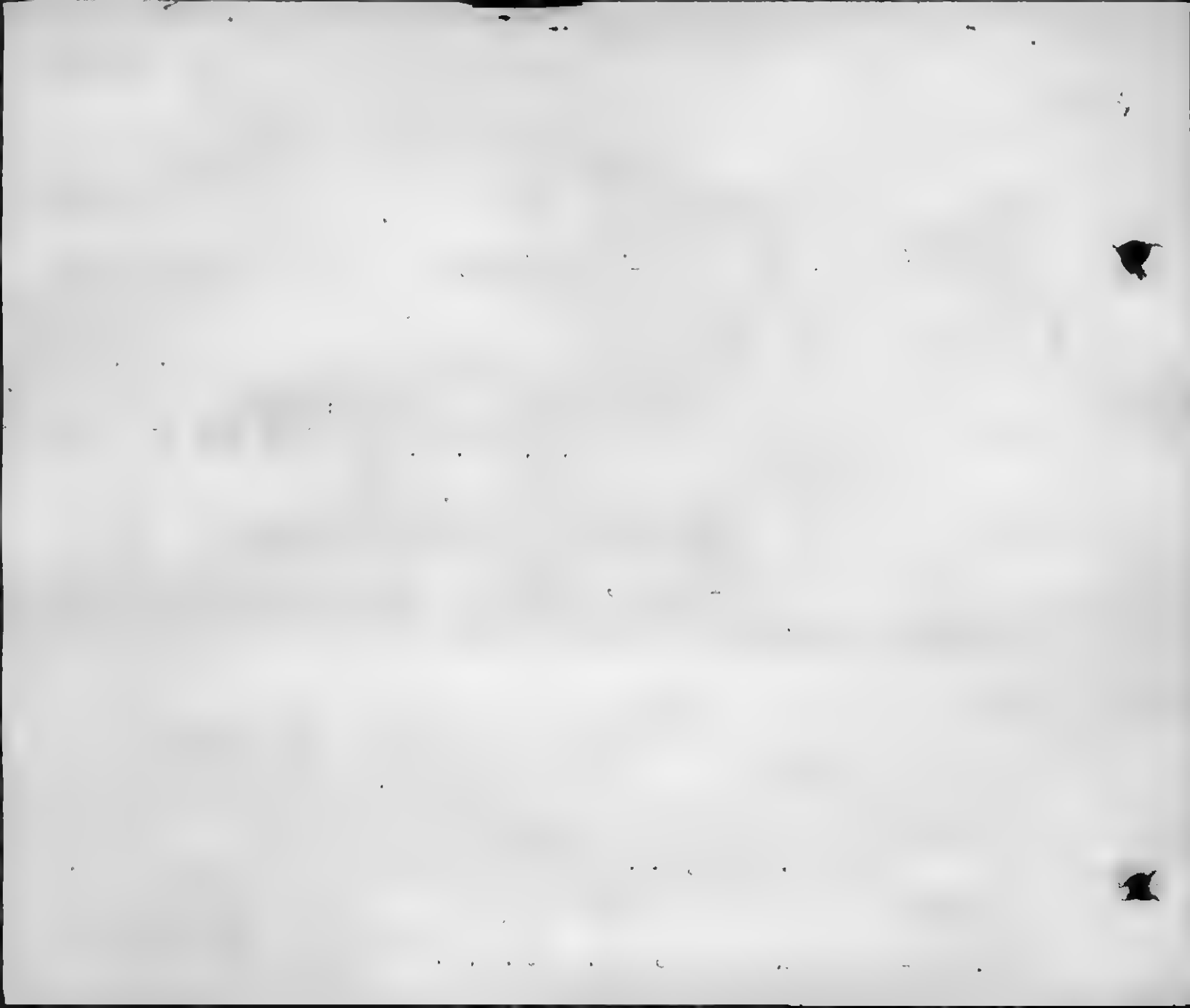


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6506
CERTIFICATE OF DEATH
06490

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission, a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 516 S. Macon Street	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN IN 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Served as GUST J. KELLY KELLIS)		4. DATE OF DEATH Month June Day 15 Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH November 16, 1887	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 73 Days 18 Hours 18 M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Worker		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kelly		14. MOTHER'S MAIDEN NAME Carrie MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Type or print) Yes WWI		16. SOCIAL SECURITY NO. VAH,BALTO.,MD., FORT HOWARD DIVISION	
17. INFORMANT Clinical Records 3900 Loch Raven Blvd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, RIGHT, MASSIVE Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE PEPTIC ULCER, STOMACH,	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BENIGN PROSTATIC HYPERTROPHY- DURATION UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 11, 1961 to June 15, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 15, 1961 , and that death occurred at A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan M.D.		22b. DATE SIGNED 6/15/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE, MD. - FT HOWARD DIV.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (S or F) Removal 6-15-61		23c. NAME OF CEMETERY OR CREMATORY Upland Cemetery	
23d. LOCATION (City, town or county) (State) Yorkville Ohio		25a. REC'D BY REGISTRAR JUN 20 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. ...	

SHIPPED TO: Burford Funeral Home, 102 Main St. Tiltonville, Ohio

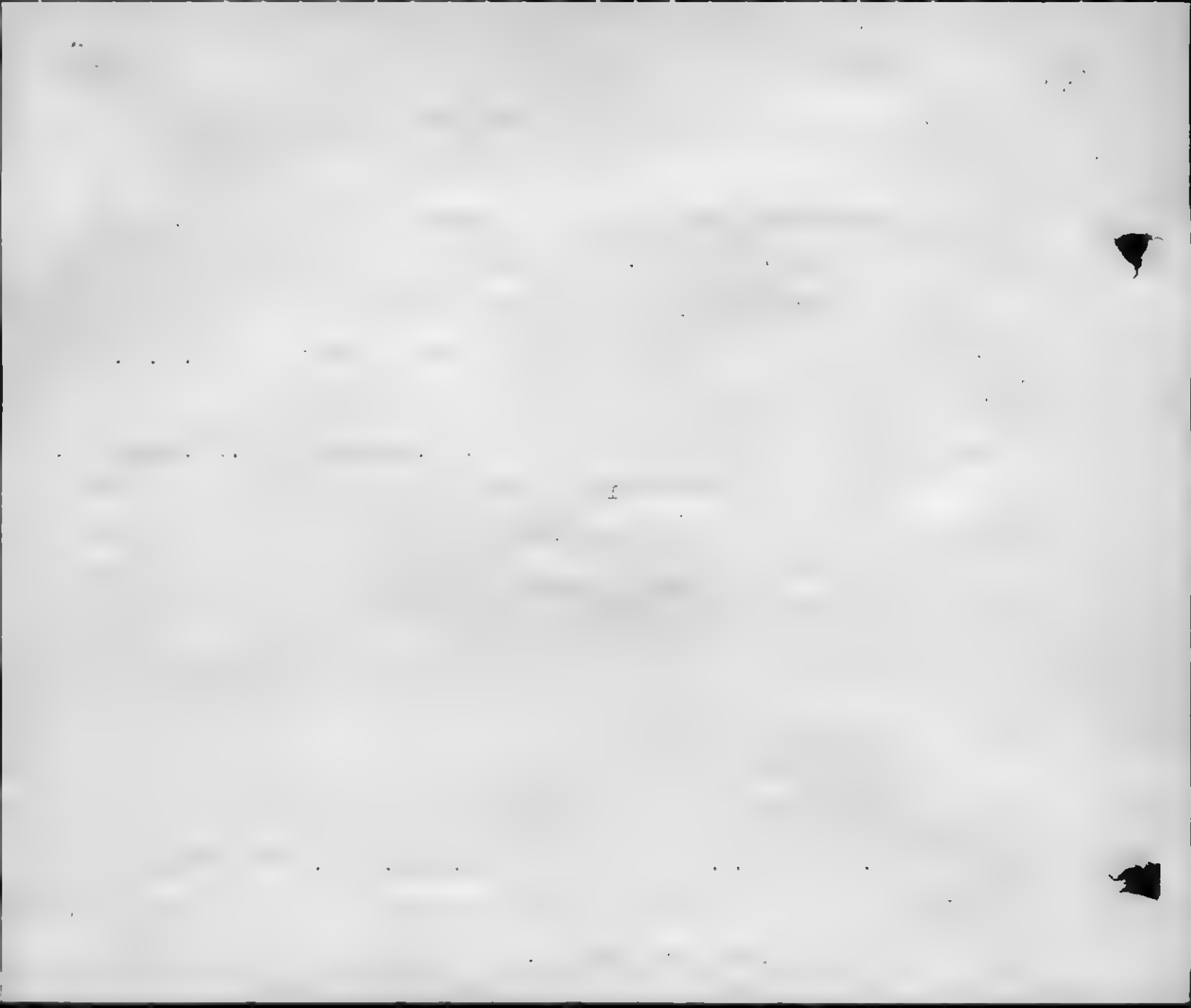


TO: **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO: **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
C507									
06491									
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard					c. LENGTH OF STAY in lb 33 Days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 2408 E. Lafayette Avenue (13)				
3. NAME OF DECEASED (Type or print) FRED E. KING					4. DATE OF DEATH June 7 19 61				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH April 29, 1888				
9. AGE (in years last birthday) 73 yrs.					10. IF UNDER 1 YEAR Months Days 7 19 61				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender					10b. KIND OF BUSINESS OR INDUSTRY Liquor				
11. BIRTHPLACE (County & State, or foreign country) Oshkosh, Wisconsin					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Casper King					14. MOTHER'S MAIDEN NAME Marie Ruckenstein				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I					16. SOCIAL SECURITY NO. 213-07-5711				
17. INFORMANT Clin. Rec. VAH, BALTIMORE 18, MD., FT. HOWARD DIV.					Address U. S. A.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4205 DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC HEART DISEASE (c), stating the underlying cause last. HODGKIN'S DISEASE, ABDOMINAL					INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from May 5 1961 to June 7 1961 , that (we) last saw the deceased alive on June 7 1961 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.					22a. SIGNATURE Thomas F. Crahan M.D. 22b. DATE SIGNED 6/7/61				
22c. PHYSICIAN'S NAME (Type or print) THOMAS F. CRAHAN, M.D.					22d. ADDRESS VAH, BALTO. 18, MD., FORT HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (specify) Burial					23b. DATE THEREOF 6-7-1961				
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery					23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Leo G. Cook, 1700 N. Patterson Park Ave.					25a. REC'D BY REGISTRAR JUN 8 '61				
25b. REGISTRAR'S SIGNATURE Charles L. Kraus									



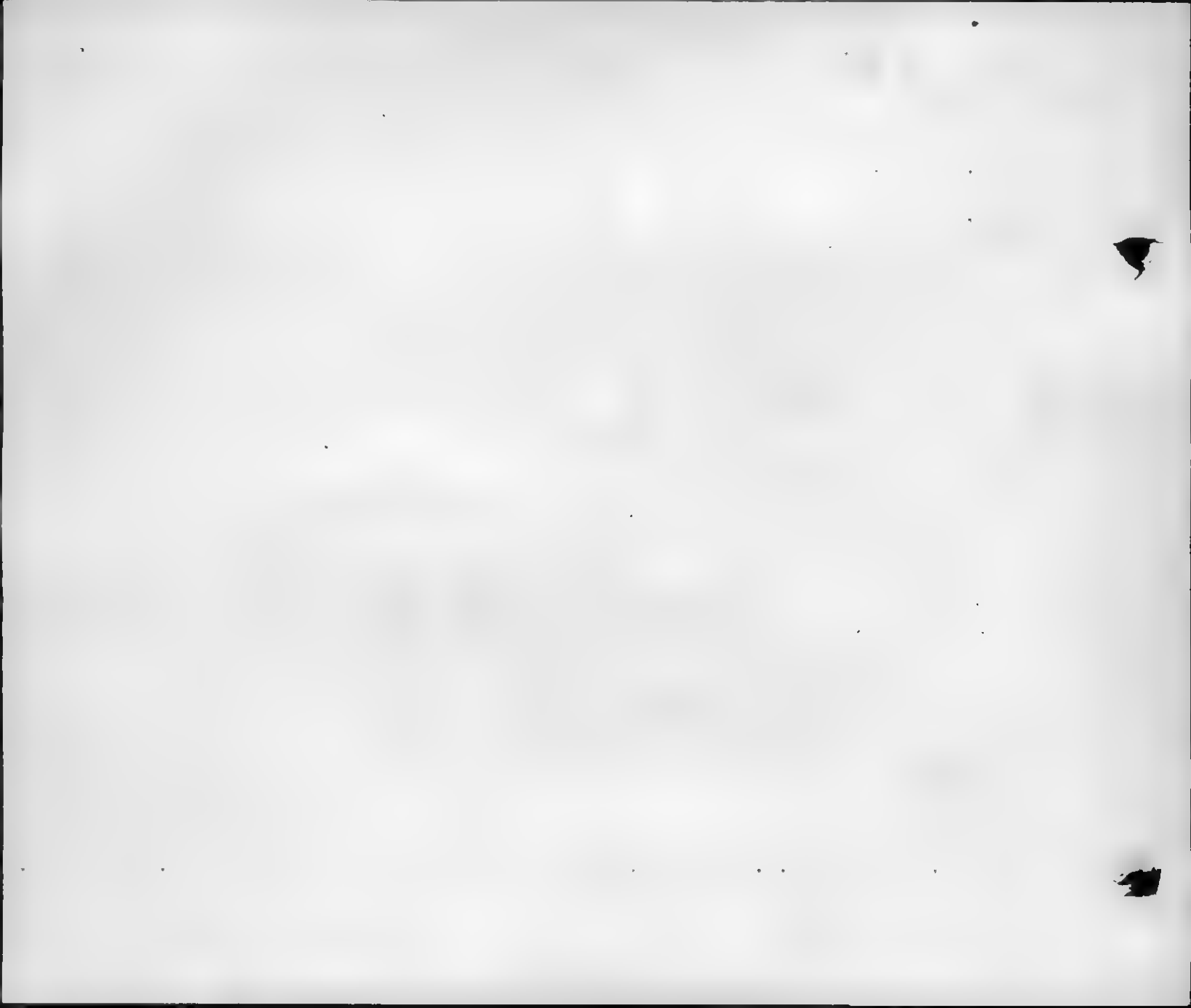
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C503

06492

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>4 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. Wilson State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>GEORGE</u> Last <u>KIRMES</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 16 1903</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	11. IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARINE ENGINE SALES ROOM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL KIRMES</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA STRUBS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-07-5320</u>	
17. INFORMANT <u>Hospital Records, W. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of left lung</u> DUE TO (b) <u>16X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>1 year</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis. Emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> , 19 <u>61</u> , to <u>6/8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/8</u> , 19 <u>61</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.	
22a. SIGNATURE <u>L. J. Newcomer</u>		22b. DATE SIGNED <u>6/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D., Superintendent</u>		22d. ADDRESS <u>W. Wilson State Hospital, W. Wilson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO CO.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. [Signature]</u>		25a. REC'D BY REGISTRAR <u>DANIEL 12 '61</u>	
ADDRESS <u>3612 Chestnut Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6509

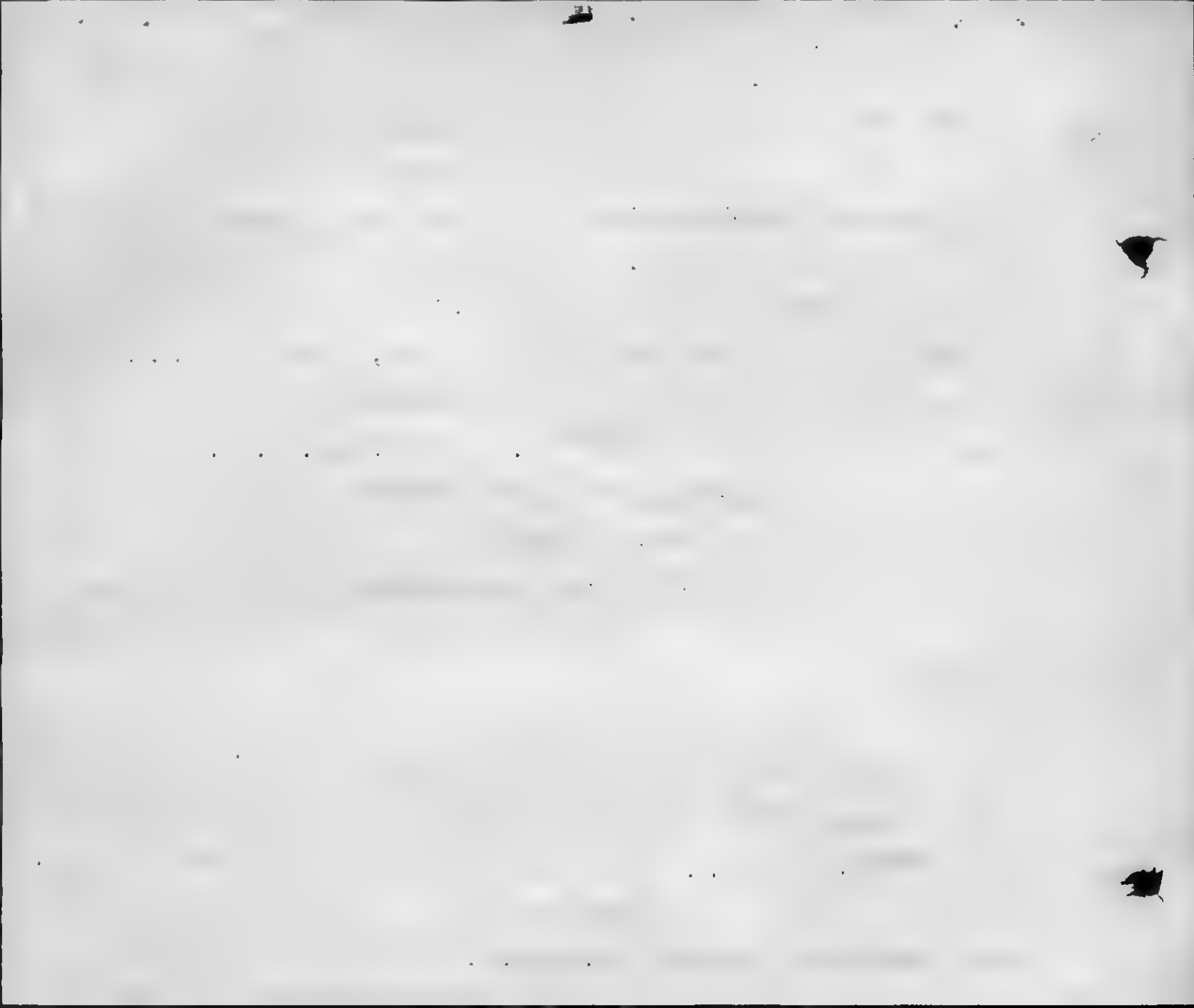
06493

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN IT <u>12 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (14) d. STREET ADDRESS <u>3209 Glenmore Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JACOB P. KRACH</u>			4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>19 61</u>		
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>May 12, 1880</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Gardenville, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Phillip Krach</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Otto</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give number and date of service) <u>SPANISH AMERICA 212-01-6196</u>			16. SOCIAL SECURITY NO. <u>212-01-6196</u> 17. INFORMANT <u>Clin. Records, VAH, Balto. Md. Ft. Howard Div.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</u> Conditions, if any, which gave rise to immediate cause (b) <u>PULMONARY EMPHYSEMA</u> (c) <u>NEPHROSCLEROSIS, ARTERIOSCLEROTIC</u>			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>UNKNOWN</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____					
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>June 3, 1961, to June 15, 1961</u> , that <u>he</u> (we) last saw the deceased alive on <u>June 15, 1961</u> , and that death occurred <u>8:05AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Thomas F. Crahan</u> 22b. DATE SIGNED <u>6/15/61</u> 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u> 22d. ADDRESS <u>VAH, BALTIMORE, MARYLAND-FT HOWARD DIV.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/19/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> 23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Heeman Funeral Home, 6067 Harford Rd., Balto. Md.</u> 25a. REC'D BY REGISTRAR <u>JUN 21 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

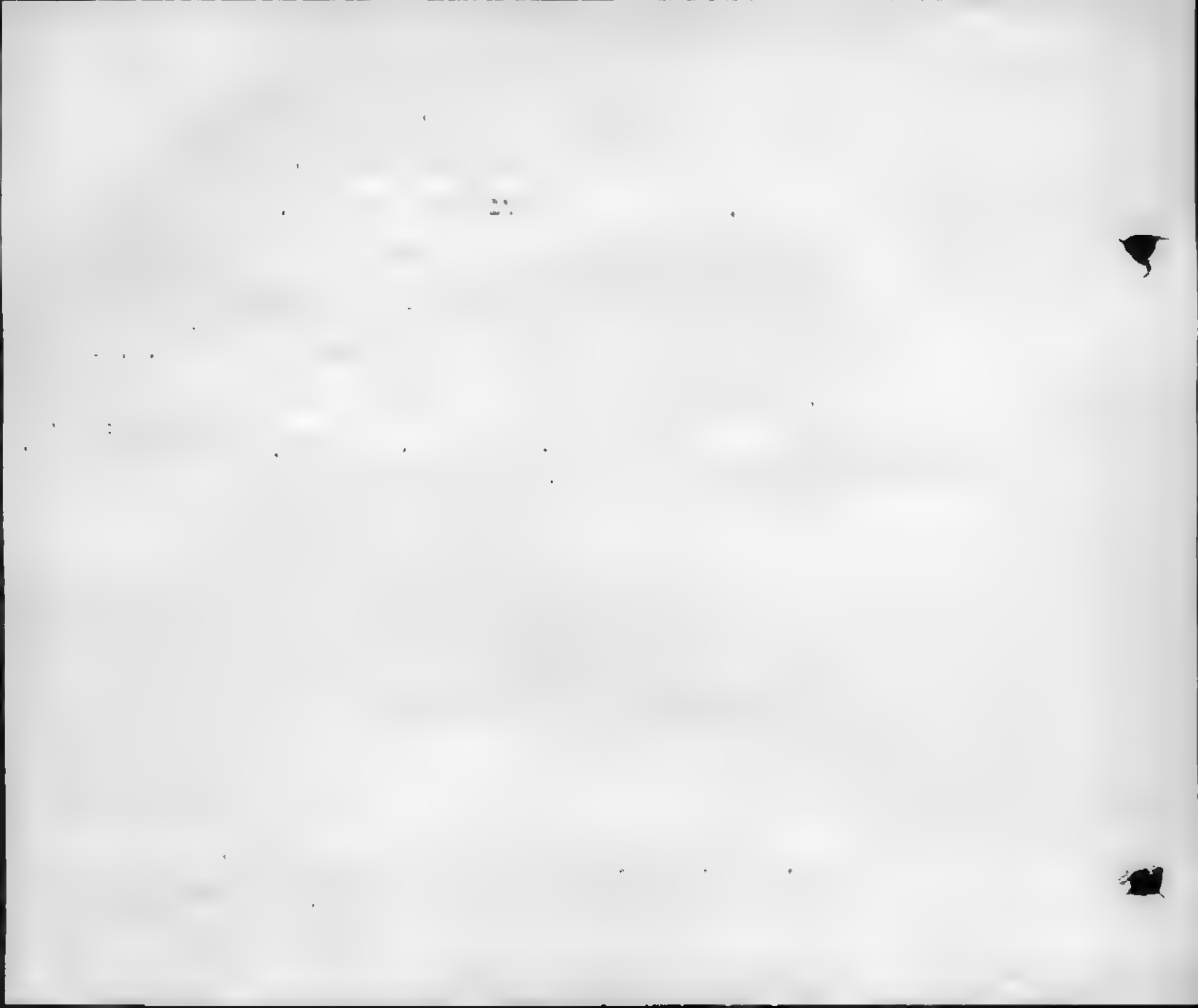


DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6510

06494

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 610 Edmondson Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dale		First Levine		Middle Lambert		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1960	
9. AGE (In years) 15 months		IF UNDER 1 YEAR Months 15 Days 00 Hours 00 Min. 00		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland	
12. FATHER'S NAME Robert L. Lambert		13. MOTHER'S MAIDEN NAME Betty Turfle		14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		15. SOCIAL SECURITY NO. None	
16. INFORMANT Mr. Robert L. Lambert		17. ADDRESS 601 Edmondson Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GASTROENTERITIS, ACUTE 1.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PAROTITIS, LEFT, CHRONIC, RESOLVING		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 29 JUN 1960 , to 13 JUN 1961 , that (I) (we) last saw the deceased alive on 13 JUN 1961 , and that death occurred at 24 M. from the causes and on the date stated above							
22a. SIGNATURE Irwin H. Moss, M. D.				22b. DATE SIGNED 14 Jun 61			
22c. PHYSICIAN'S NAME (Type) Irwin H. Moss, M. D.				22d. ADDRESS 5836 Baltimore Nat'l Pike			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF June 16, 1961		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.				25a. REC'D. BY REGISTRAR JUN 26 61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6511

06495

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>903 Breezewick Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>903 Breezewick Road</u>	
3. NAME OF DECEASED (Type or print) <u>Myrtle Lee</u> 4. DATE OF DEATH <u>6</u> <u>16</u> <u>1961</u> 5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-11-1898</u> 9. AGE (In years last birthday) <u>62</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE County & State, or foreign country <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph M. Bolger</u> 14. MOTHER'S M.A.DEN NAME <u>Julia Fullem</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>MARTIN Schwemmer</u> 17. INFORMANT <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>722.1</u> DUE TO <u>Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>			
20c. TIME OF INJURY Month, Day, Year <u>Feb</u> <u>1960</u> 20d. INJURY OCCURRED <u>While at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>9005 Harford Rd</u> 20f. (City or town) <u>BALTIMORE</u> (County) <u>Md.</u> (State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> <u>1960</u> to <u>June</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>6/16/61</u> and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank T. Kasik</u> 22c. PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK</u>		22b. DATE SIGNED <u>6/16/61</u> 22d. ADDRESS <u>9005 Harford Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>6/19/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> 23d. LOCATION (City, town or county) <u>BALTIMORE</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. RUCK</u> 25a. REC'D BY REGISTRAR <u>JUN 20 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

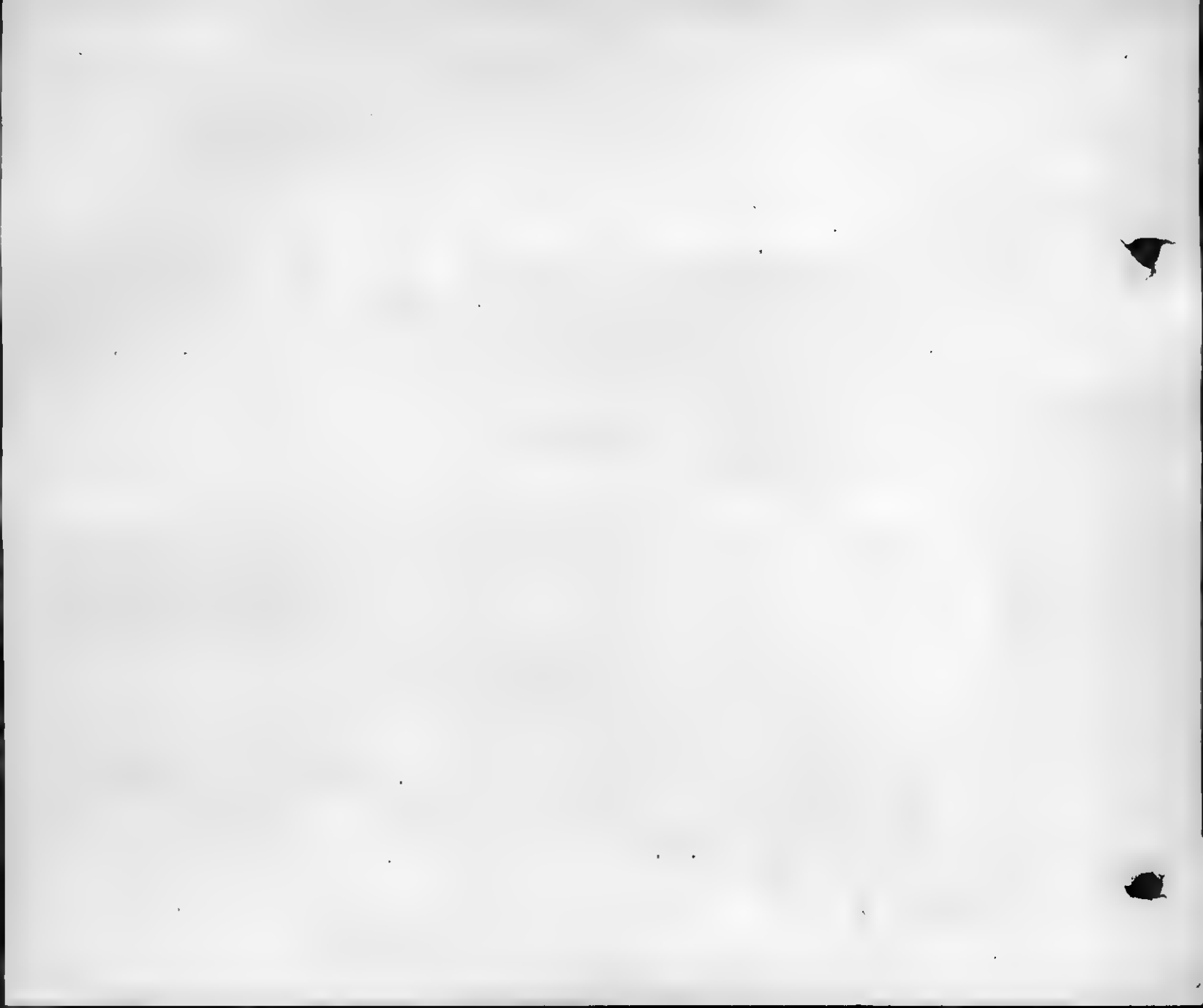
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0512

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06496

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Haford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yr2mth24dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Maryland	
		d. STREET ADDRESS R.F. D. #1	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Joseph Last Leight		4. DATE OF DEATH Month June Day 9 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 Sept. 28, 1887
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 3 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telegraph operator		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Leight		14. MOTHER'S MAIDEN NAME Margaret Baungart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 219-22-7192	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 19 61 to June 9, 19 61 that (I) (we) last saw the deceased alive on June 9, 19 61 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Loretta Hsu		22b. DATE SIGNED 6-9-61	
22c. PHYSICIAN'S NAME (Type) Loretta Hsu, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/1961	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City, town, or county) (State) Bel Air, Harford, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard McComas Aberdeen		25a. REC'D BY REGISTRAR DATE JUN 14 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hsu	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06497**

6513

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 1 506 C STREET	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIAM LEONARD		4. DATE OF DEATH Month Day Year JUNE 24 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3, 1870
9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL WORKER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS LEONARD		14. MOTHER'S MAIDEN NAME MARY BATTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 204-10-0085	
17. INFORMANT Frank L. Smith Address Cockeysville, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arterio Sclerotic Cardio Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease (c) 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3 19 53 , to 6-24 19 61 , that I last saw the deceased alive on 6-23 19 61 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville, Md DATE SIGNED 6/24/61 ACTUAL SIGNATURE Walter T. Kees M.D. PHYSICIAN'S NAME (Type) WALTER T. KEES COCKEYSVILLE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-27-61	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville 8, Md
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUN 27 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN b <u>4 days</u>		d. STREET ADDRESS <u>105 S. Beechfield Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Douglas Leslie</u>		4. DATE OF DEATH <u>June 20 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>model maker machinist-Westinghouse</u>		9. AGE (In years last birthday) <u>66</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Leslie</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Laing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>015-03-7070</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarctive myocardial fibrosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>422.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 16 1961</u> to <u>June 20 1961</u> that (I) (we) last saw the deceased alive on <u>June 20 1961</u> , and that death occurred at <u>6:30 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler</u>		22b. DATE SIGNED <u>6-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		25a. REC'D BY REGISTRAR <u>JUN 23 '61</u>	
ADDRESS <u>4107 Wilkens Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

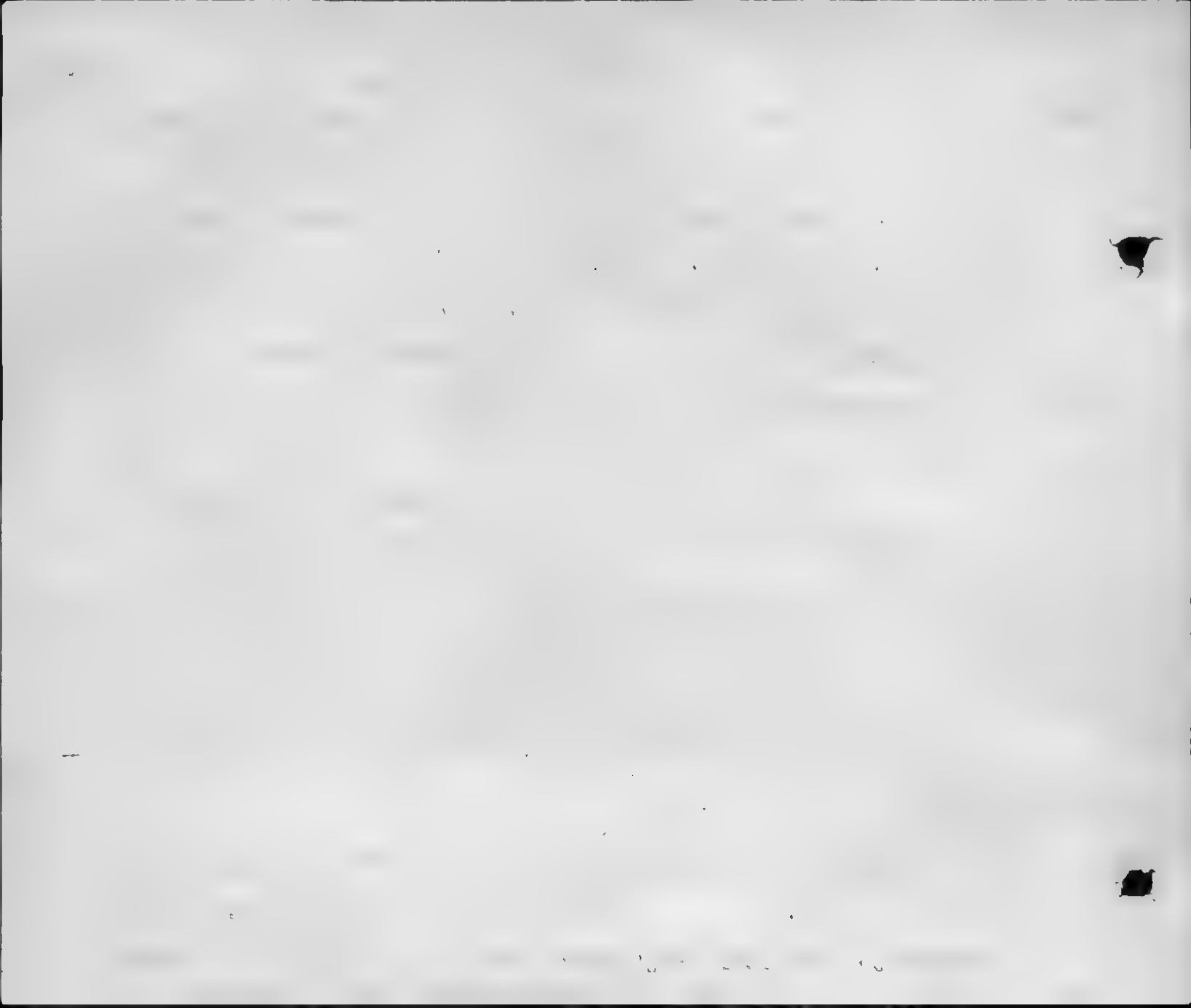
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN b. <u>1505 Chilworth Avenue</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1505 Chilworth Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>1505 Chilworth Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Sadie E. Mackley Lewis</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>June 10th 1961</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins. <u>0</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Wooden</u>		14. MOTHER'S MAIDEN NAME <u>Martha</u> ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NO</u> 17. INFORMANT <u>Address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3128 Harford Rd.</u>	
20f. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>Maryland</u>		21. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> 19 <u>60</u> to <u>6/10</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>6/6</u> 19 <u>61</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Conrad L. Richter</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>June 13 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Conrad L. Richter</u>		22d. ADDRESS <u>3128 Harford Rd.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/13/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> 23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR <u>June 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Conrad L. Richter</u>		25c. DATE <u>June 13 '61</u>	

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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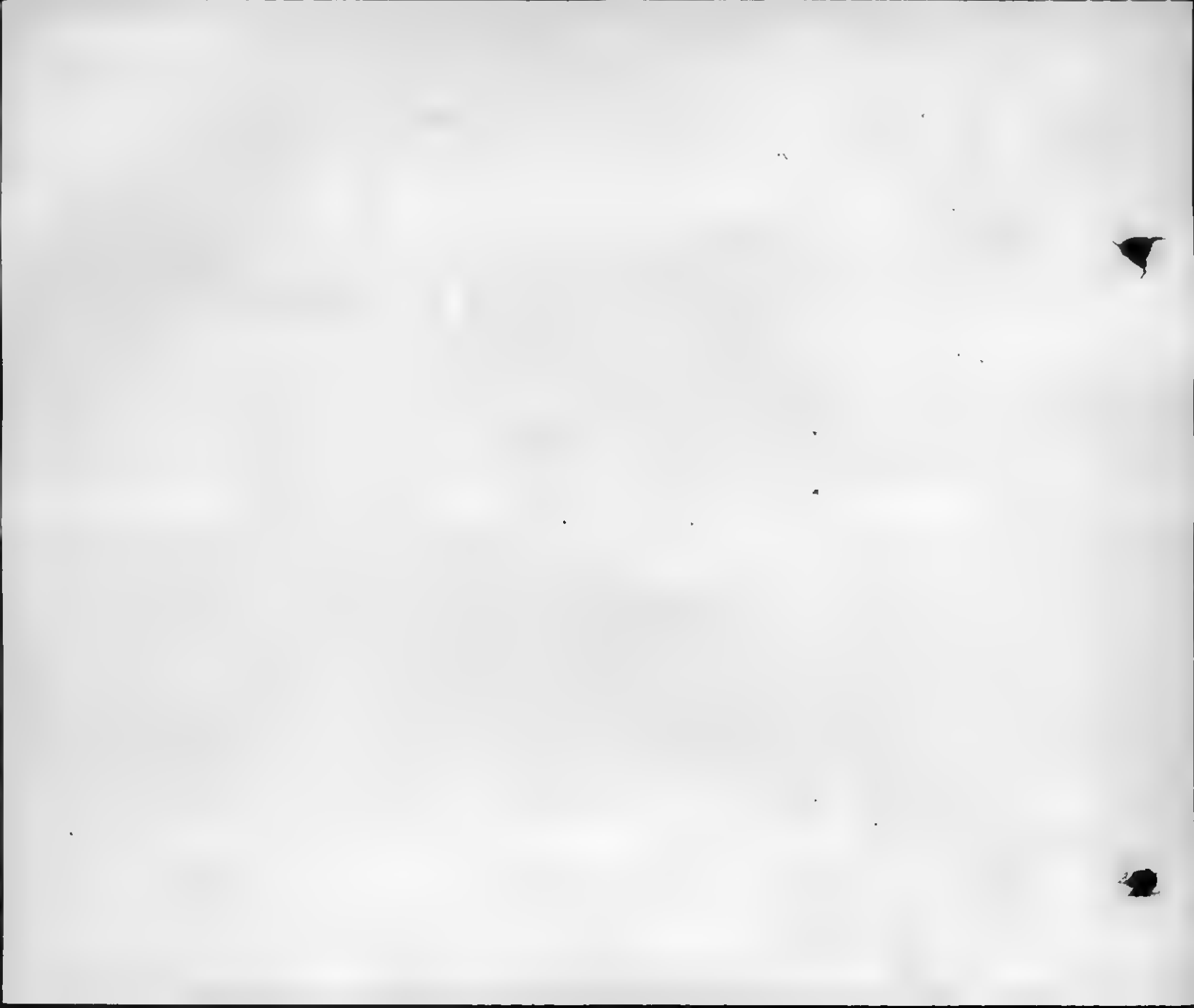
06500

1. PLACE OF DEATH a. COUNTY <u>Luttrell</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luttrell</u>				c. LENGTH OF STAY IN 1b <u>---</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Augsburg Home</u>				d. STREET ADDRESS <u>4213 CONNECTICUT Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sophia Fredericka LOTZ</u>				4. DATE OF DEATH Month Day Year <u>6 17 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1867</u>		9. AGE (In years lost birthday) <u>94</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Dietsch</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE Rensch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Augsburg Home Recorder 6811 Campfield Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5-7 days</u> <u>1 day</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>---</u> 19 <u>---</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
				20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> , 19 <u>61</u> , to <u>6/17</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/16</u> , 19 <u>61</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Earl L. Chambers</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>				22d. ADDRESS <u>4108 Liberty Hts. Ave Balto-md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Luttrell Park</u>		23d. LOCATION (City, town, or county) <u>Balto. md.</u> (State) <u>---</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mike Webb + Son</u>				ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 21 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

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CERTIFICATE OF DEATH

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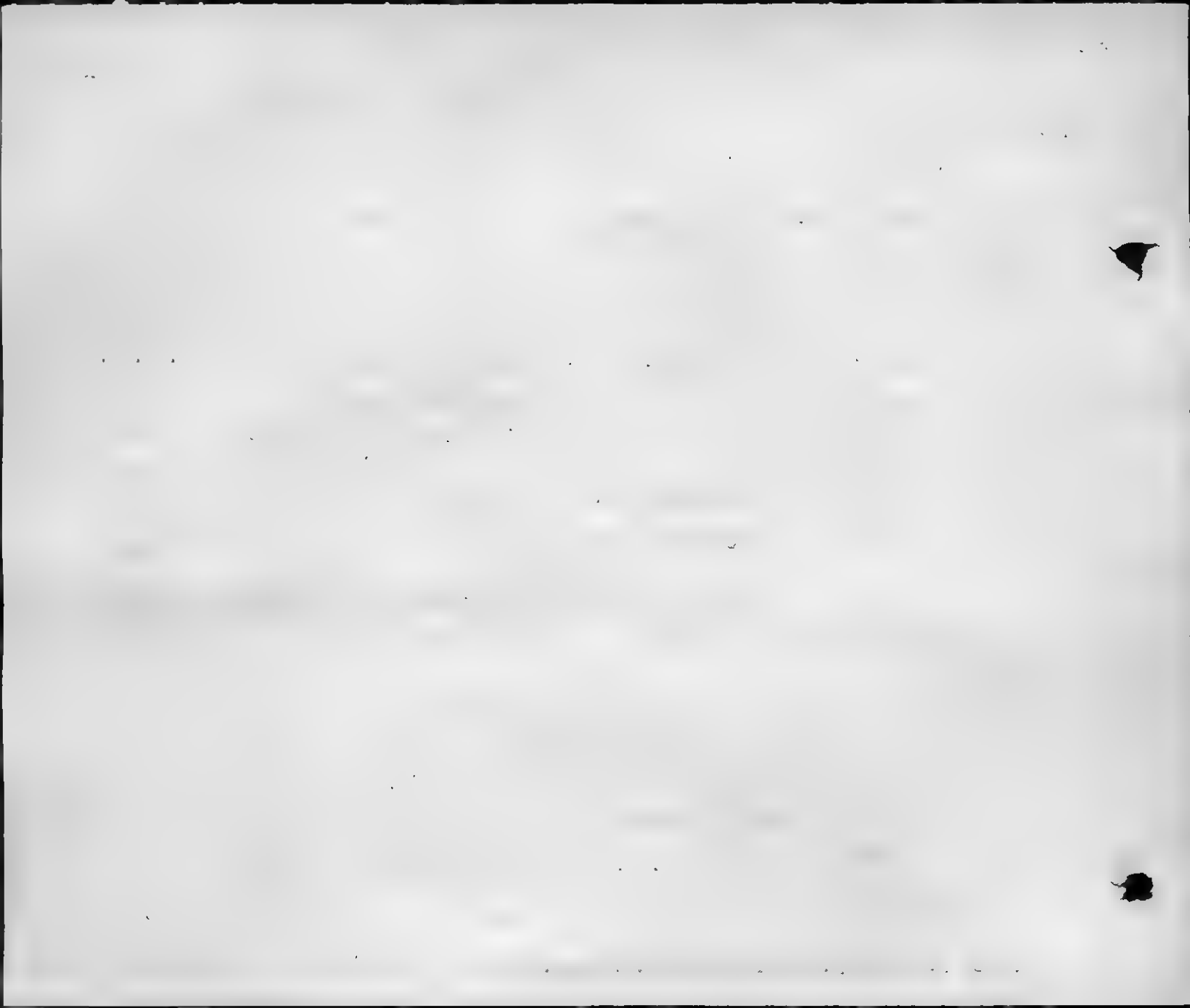
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				b. COUNTY			
Baltimore				Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Fort Howard				Brooklyn			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
Veterans Administration Hospital				3722 - Sixth Street			
3. NAME OF DECEASED				4. DATE OF DEATH			
First Middle Last				Month Day Year			
ALBERT				June 22 1961			
5. SEX				6. COLOR OR RACE			
Male				White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				September 1, 1894			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Bag Printer				Fertilizer Co.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Asa Lowman				Margaret Rhoades			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				17. INFORMANT			
Yes WW I				Clinical Records, VA Hospital, Baltimore 18, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. AGE (In years last birthday) yrs. Months Days Hours Min.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL				IF UNDER 1 YEAR Months Days Hours Min.			
DUE TO (b) CEREBRAL THROMBOSIS, LEFT				INTERVAL BETWEEN ONSET AND DEATH RECENT			
DUE TO (c) CEREBRAL ARTERIOSCLEROSIS				RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE - Duration Unknown				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (he/she) (this hospital) attended the deceased from May 20, 1961, to June 22, 1961, that (he/she) (we) last saw the deceased alive on June 22, 1961, and that death occurred at 8:30 P.M. from the causes and on the date stated above				22a. SIGNATURE Thomas F. Crahan M.D.			
22b. DATE SIGNED 6/22/61				22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M. D.			
22d. ADDRESS VAH, BALTIMORE 18, MARYLAND FORT HOWARD DIVISION				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-26-61			
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) Anne Arundel County, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE James L. McCully				25a. REC'D BY REGISTRAR JUN 26 '61			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

VR A15 (4)
15M 9/60



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6518

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1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12mo-2d</u> c. LENGTH OF STAY IN 1b. <u>Balto</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Pratt Hosp.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4608 Roland Ave</u> d. STREET ADDRESS <u>4608 Roland Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Susan</u> Middle <u>Lupton</u> Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 19 1865</u> 9. AGE (In years last birthday) <u>95</u> yrs. IF UNDER 1 YEAR Months Days Hours Min 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pub Sch.</u> 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				4. DATE OF DEATH <u>June 2</u> 19 <u>61</u> 13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Hosp Records</u> Address <u>—</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Brain Synd. & Senile Paran. Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <u>7mo</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State) <u>—</u>									
21. I certify that (I) (this hospital) attended the deceased from <u>May 25</u> 19 <u>61</u> to <u>June 2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive at <u>May 1</u> 19 <u>61</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above 22a. SIGNATURE <u>W. W. Elgin</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>6/2/61</u> 22c. PHYSICIAN'S NAME (Type) <u>W. W. Elgin</u> 22d. ADDRESS <u>Sheppard Pratt Hosp. Towson Md</u>									
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>6-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc. 1900 Eutaw Pl</u> ADDRESS <u>—</u>				25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u>					



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

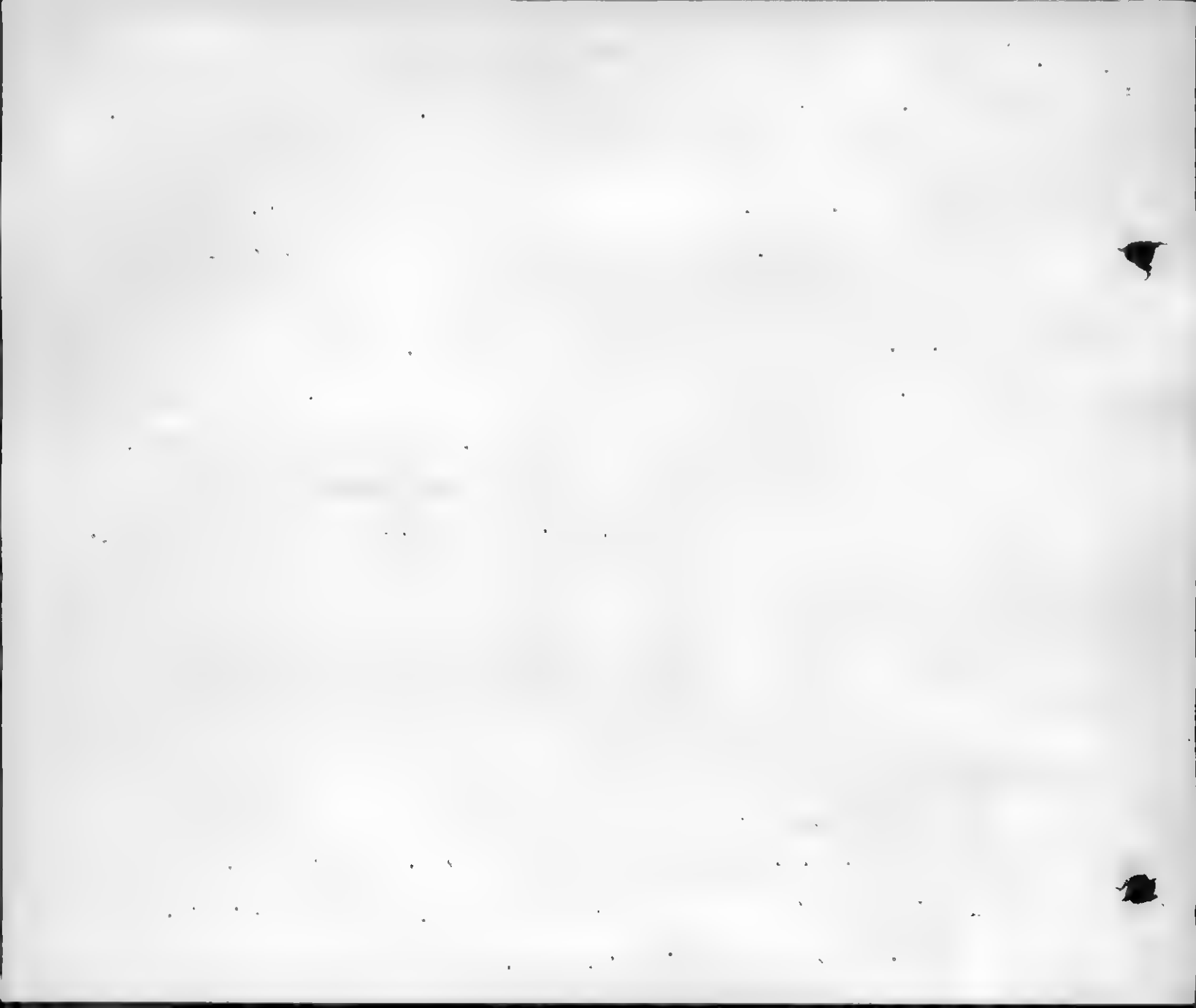
CERTIFICATE OF DEATH

Reg. Dist. No. 06503

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1607 Potomac Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida M. Middle Lutz Last Lutz				4. DATE OF DEATH Month June Day 29 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/1888	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 7 Days 2 Hours 0 Min 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Md.				13. FATHER'S NAME John L. Farley			
14. MOTHER'S MAIDEN NAME Margrette ???				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO unknown				17. INFORMANT Earl F. Lutz 1607 Potomac Ave. (son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 44 3X DUE TO Hypertensive Cardio Vascular disease Residual hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Residual hemorrhage DUE TO (c) Residual hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 28 , 19 61 , to June 28 , 19 61 , that I last saw the deceased alive on June 28 , 19 61 , and that death occurred at M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles Tommasello M.D.				PHYSICIAN'S NAME (Type) Dr. C.J. Tommasello 910 W. Lombard St.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/61		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.			
24a. REC'D BY REGISTRAR DATE JUL 3 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 06504

1. PLACE OF DEATH = COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1918 Gettysburg Rd</u>		d. STREET ADDRESS <u>1915 Altamere Road</u>	
3. NAME OF DECEASED (Type or print) <u>Nicholas</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) yrs. <u>71</u>
13. FATHER'S NAME <u>George Mabe</u>		14. MOTHER'S MAIDEN NAME <u>Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jessie L. Anderson</u>		Address <u>1915 Altamere Rd - 28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>18100</u> DUE TO <u>Carcinoma of Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Urinary) with metastases</u> DUE TO (c) <u>to Inguinal glands Bilat.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 60</u> to <u>6/18/61</u> , that I last saw the deceased alive on <u>6/16/61</u> , 19 <u>61</u> , and that death occurred at <u>300A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGrath</u>		DATE SIGNED <u>6/18/61</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGrath</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-21-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Max Anderson</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '61</u>	
ADDRESS <u>Catonsville 28</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kneud</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



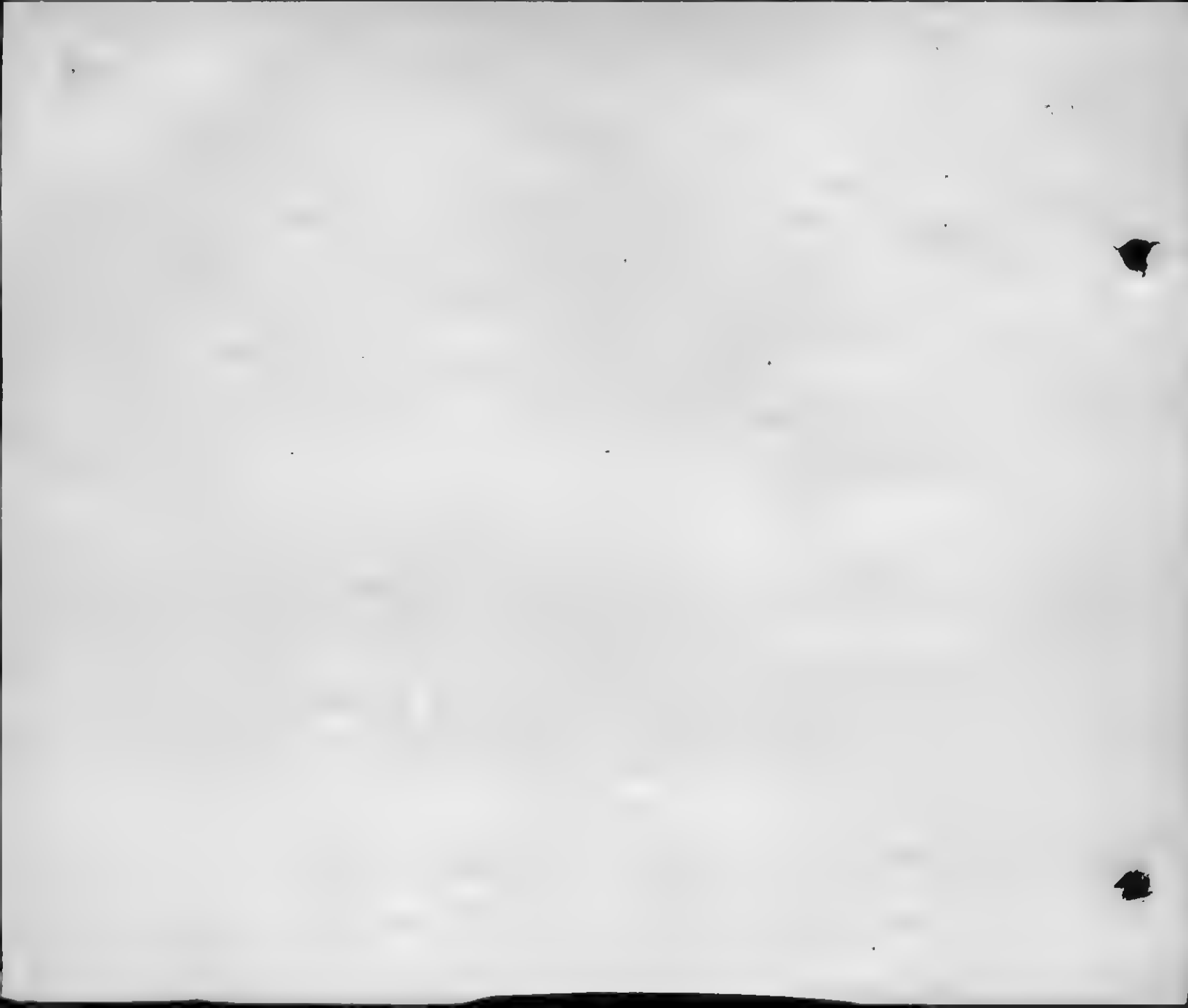
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FOR STATE
HEALTH DEPT. M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
06505																													
1. PLACE OF DEATH a. COUNTY Baltimore County			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson			c. LENGTH OF STAY IN 1b 2 hrs			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland			b. COUNTY Baltimore City			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13, Maryland			d. STREET ADDRESS 3618 Bonview Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Richard R. MacCubbin			4. DATE OF DEATH Month 6 Day 9 Year 19 61			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3/15/87			9. AGE (In years last birthday) 74 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Elevator Opr.			11. BIRTHPLACE (State or foreign country) Maryland - Baltimore			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles Maccubbin			14. MOTHER'S MAIDEN NAME Cora Palmer			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 216 219-09-0298			17. INFORMANT Medical records, Mt. Wilson State Hospital			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Subsidiary Ite.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>6 mo.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			20c. TIME OF INJURY Month, Day, Year <u>June 13 1961</u> Hour a.m. p.m. <u>7:00</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>			20f. (City or town) (County) (State)														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 6-9-61										
ACTUAL SIGNATURE <u>E. E. Tappan</u>			EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>			22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/13/61			22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.			22d. LOCATION (City, town, or country, (State) Baltimore, Md.														
23. FUNERAL DIRECTOR Charles E. Schimunek Funeral Home 3331 Brehms Lane										24a. REC'D BY REGISTRAR DATE JUN 13 '61			24b. REGISTRAR'S SIGNATURE Arthur L. Kraus																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

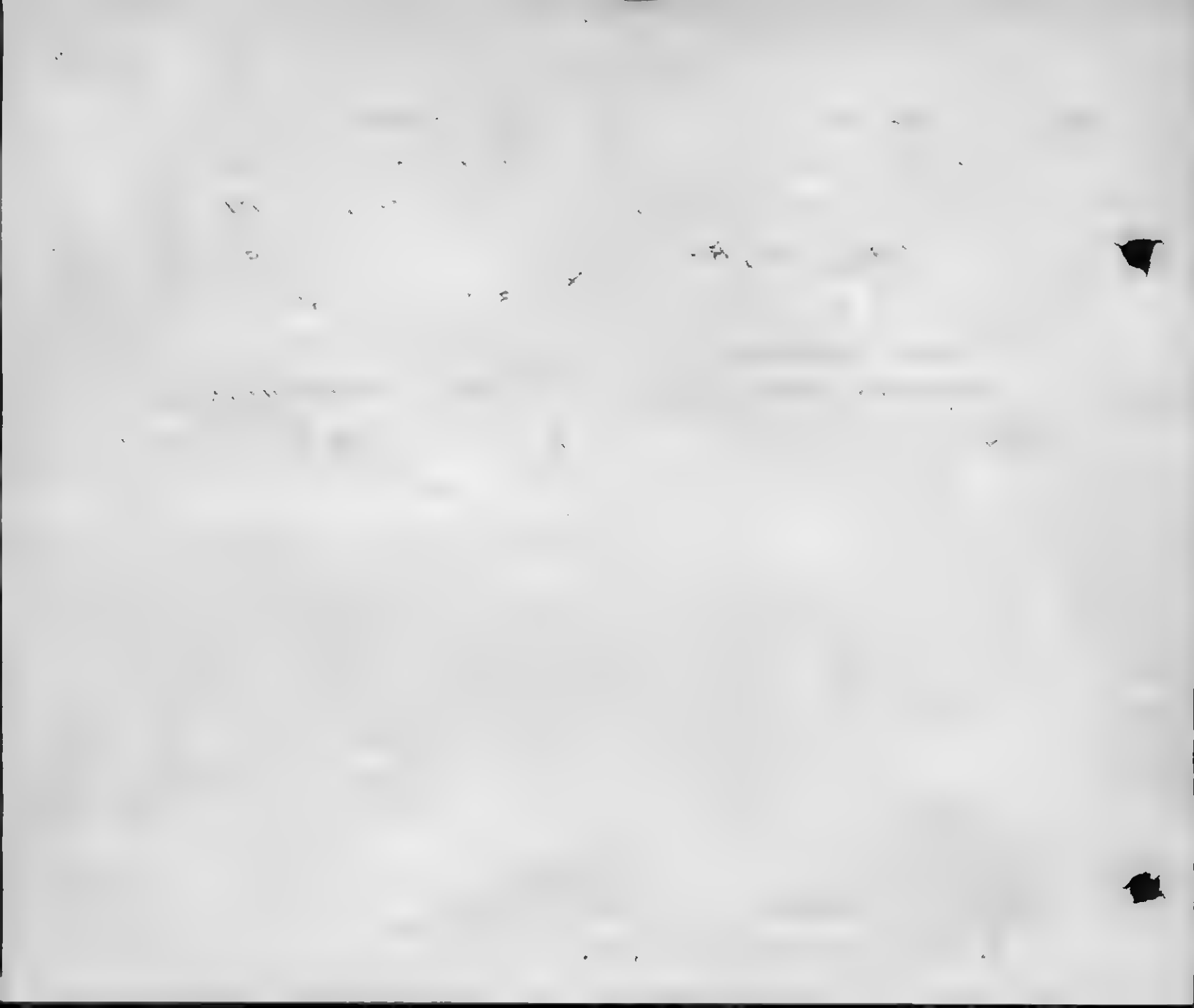
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6522

06506

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BLADENSBURG</u> d. STREET ADDRESS <u>5220 TILDEN RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAGUIRE, RALPH</u> First Middle Last		4. DATE OF DEATH <u>6</u> <u>24</u> <u>1961</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3-21-06</u> Last		9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR <u>55</u> Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER-DECORATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>	
13. FATHER'S NAME <u>FRANCIS MAGUIRE</u>		14. MOTHER'S MAIDEN NAME <u>THAIDER MAGUIRE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>RECORDS: SPRING GROVE STATE HOSP</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>42-1</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Coronary thrombosis 4.1.1961</u> DUE TO (c) <u>Chronic cardiac-vascular disease</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>2 months 24 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from June 6th 1961 to June 27th 1961, that (I) (we) last saw the deceased alive on June 24th 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Bertrude J. Fleischmann</u>		22b. PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN</u>		22c. DATE SIGNED <u>6-26-1961</u>	
22d. ADDRESS <u>Spring Grove State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	
23d. LOCATION (City, town or county) <u>Washington D C</u>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24b. ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 28 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

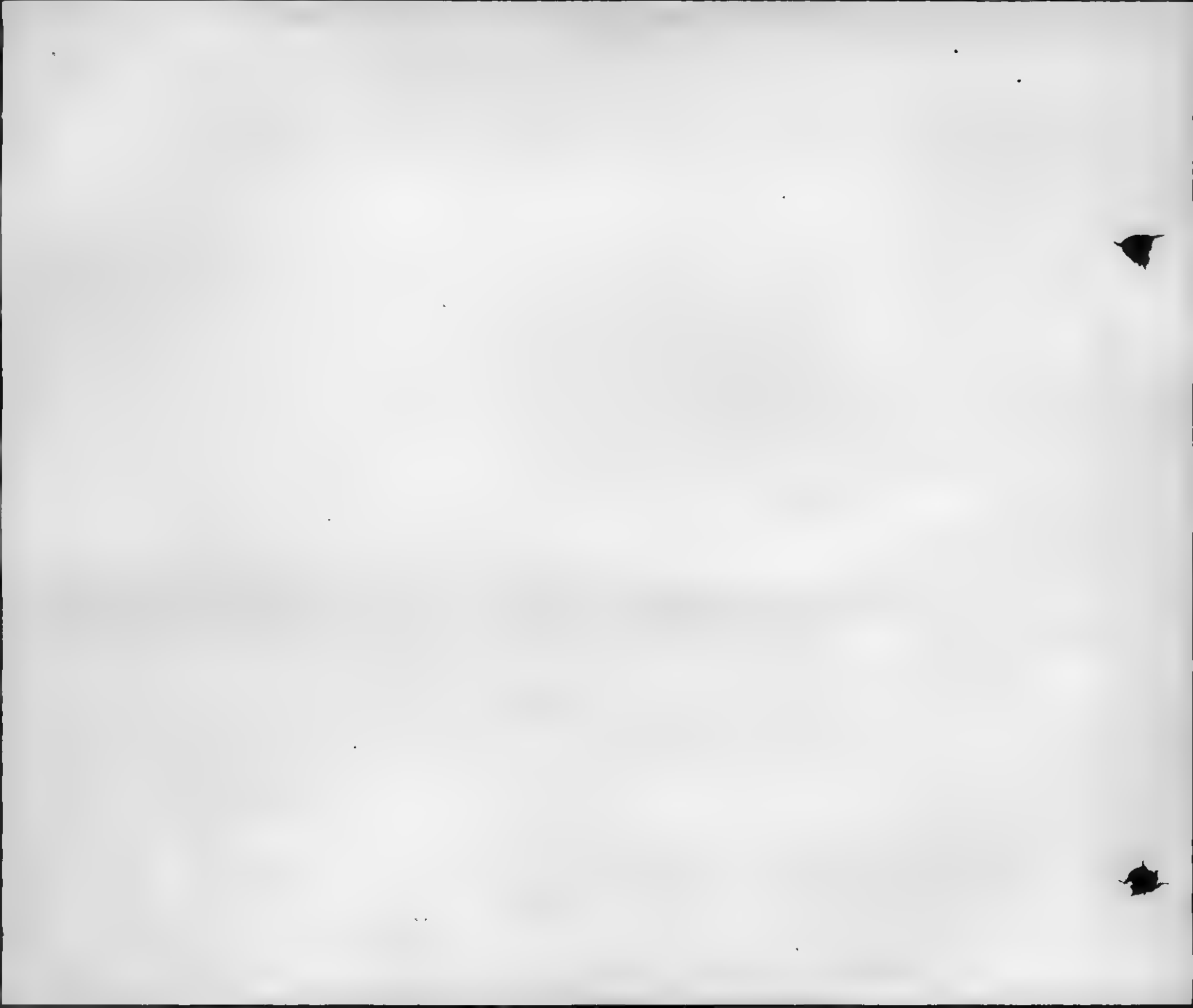
Reg. Dist. No.

06507

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>124 Sallers Pt. Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
III. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Malone</u>		4. DATE OF DEATH <u>June 17</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27/1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Thomas Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>213-264846</u>	
17. INFORMANT <u>Hugh P. Henneberry, Rev.</u>		Address <u>140 Oak Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease (Infarct)</u> DUE TO <u>Hypertensive Cardio-Vascular Disease. Arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>104</u> (c) <u>124</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 24 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 16</u> to <u>June 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>61</u> , and that death occurred on <u>June 17</u> , 19 <u>61</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wado</u>		DATE SIGNED <u>6-17-61</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wado M.D.</u>		<u>Dundalk Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 21, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Walter R. Williams</u>		24a. REC'D BY REGISTRAR <u>JUN 22 '61</u>	
ADDRESS <u>322 N. Phoenix St. Baltimore, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



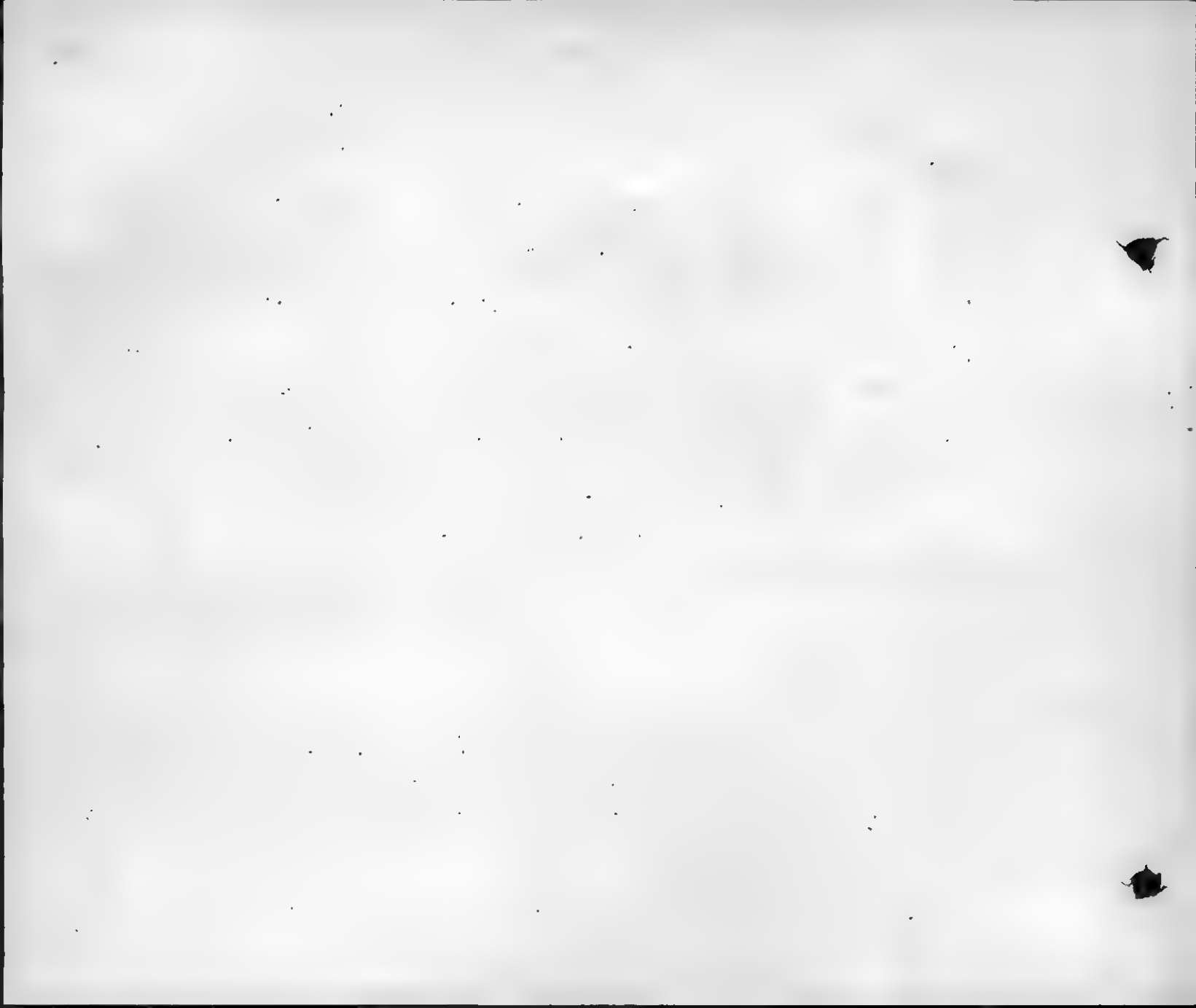
6524

CERTIFICATE OF DEATH

Reg. Dist. No. 96508

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 7 WKS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 FAIRWAY DR.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYRTLE B. Middle MALONEY Last MALONEY		4. DATE OF DEATH Month JUNE Day 27 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1896
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 14 Min 4	11. IF UNDER 24 HRS. Months 6 Days 4 Hours 14 Min 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK HERRING		14. MOTHER'S MAIDEN NAME MARY VAIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mrs. Dorothy E. Frederick - 707 Fairway Dr.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis. 153-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Carcinoma of colon. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTO., MD.		(County) (State)	
21. I certify that I attended the deceased from ap , 1961, to June 27, 1961 , that I last saw the deceased alive on June 20 , 1961, and that death occurred at 2 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold H. Burns		ADDRESS (Street, city or town, state) 115 E. Fager St. DATE SIGNED 6-27-61	
PHYSICIAN'S NAME (Type) Harold H. Burns		22a. REC'D BY REGISTRAR DATE JUN 29 '61	
22b. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	
22d. DATE THEREOF 6/30/61		22e. LOCATION (City, town, or county) (State) BALTO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Dorothy Miller, 2334 Jefferson St.		24. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
6525 CERTIFICATE OF DEATH C6509															
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN TB <u>17yr6mthl1dys</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				d. STREET ADDRESS <u>3515 Hickory Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>19 61</u>				5. AGE (in years last birthday) <u>60</u> yrs.			
3. NAME OF DECEASED (Type or print) <u>Walter S. Marsh</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1900</u>		9. AGE (in years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Brands</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Isaca Marsh</u>				14. MOTHER'S MAIDEN NAME <u>Ida Jackson</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-09-2708</u>				17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>422.1</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>-</u>												INTERVAL BETWEEN ONSET AND DEATH <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>-</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>				20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1961</u> , to <u>June 26, 1961</u> that (I) (we) last saw the deceased alive on <u>June 26, 1961</u> , and that death occurred at <u>3:40 p.m.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Stella Wachsler</u>				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>6-26-61</u>				22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/30/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Ridge</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore</u> <u>Co.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Chiswell Jr.</u>				ADDRESS <u>3617 Chestnut Ave</u>				25a. REC'D BY REGISTRAR <u>JUN 30 61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06510

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>82 Days</u>		d. STREET ADDRESS <u>2543 McCulloh Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CYRUS</u> <u>W.</u> <u>MARSHALL, Sr.</u>		4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>10</u> <u>19 61</u>	
5. SEX <u>Male</u> <u>Colored</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/27/91</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thorney G. Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>215-14-3039</u>	
17. INFORMANT <u>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> (c) <u>MALNUTRITION</u> <u>CARCINOMA OF RECTUM WITH METASTASIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>1 YEAR</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>March 20, 1961</u> , to <u>June 10, 1961</u> , that (2) (we) last saw the deceased alive on <u>June 10, 1961</u> , and that death occurred at <u>2:00PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>OTTO C. BEYER, M.D.</u>		22b. DATE SIGNED <u>6/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>OTTO C. BEYER, M.D.</u>		22d. ADDRESS <u>VAH, BALTO. MD. FORT HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>June 14, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>	
24. ADDRESS <u>802-08 Madison Ave. Baltimore 17, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 15 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			



2. 10. 1941

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

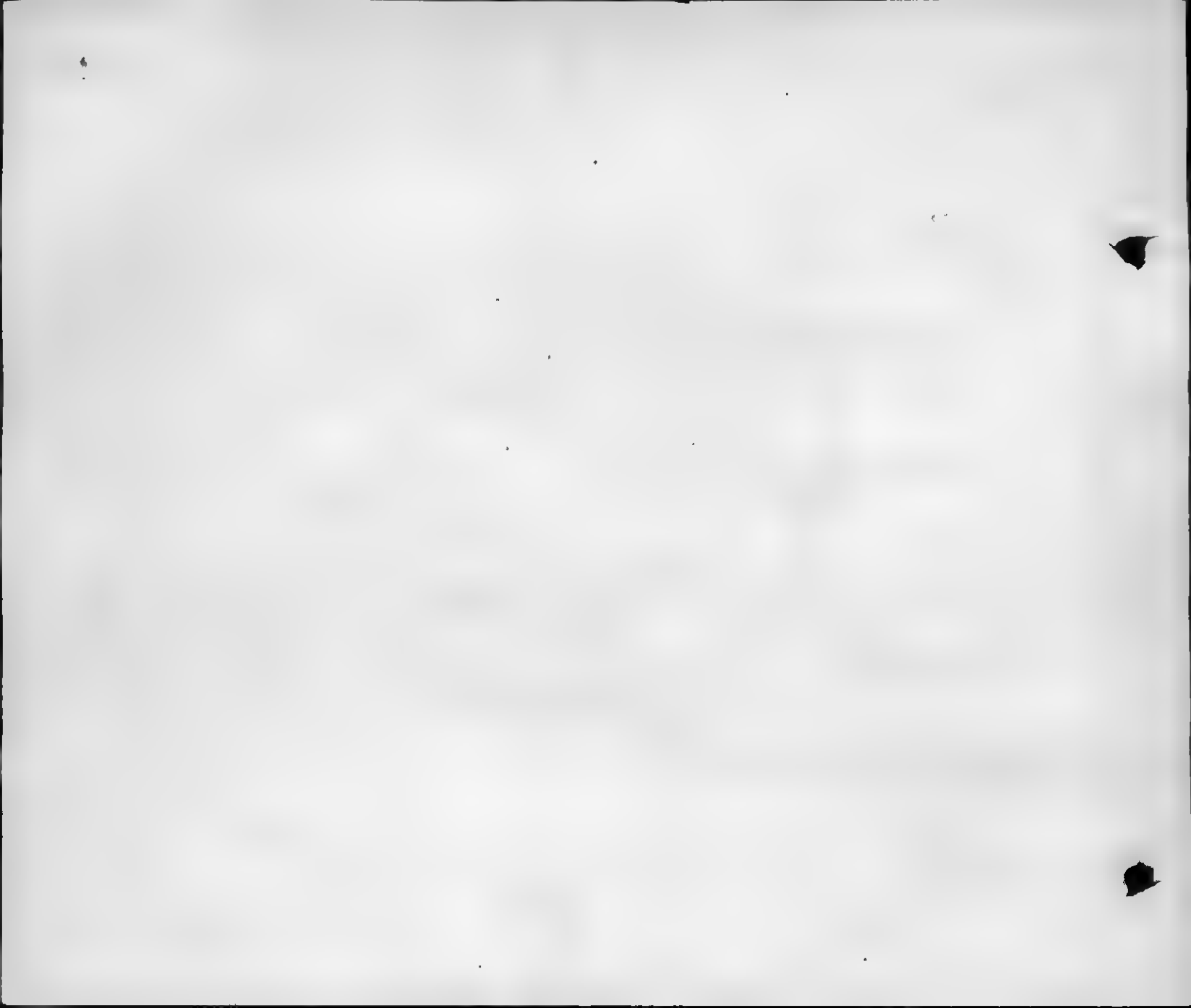
6527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06511

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Edgemere (19)</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Res., 2402 Manning Avenue</u>		e. STREET ADDRESS <u>2402 Manning Avenue</u>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last <u>RALPH H MARSHALL</u>		4. DATE OF DEATH Month Day Year <u>JUNE 13 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-19-1910</u>
9. AGE (In years last birthday) <u>51 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Lehr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>203-01-7042</u>	
17. INFORMANT <u>Mrs. Janet Marshall</u>		Address <u># 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Melvin P. Davis</u>		DATE SIGNED <u>6/14/61</u>	
EXAMINER'S NAME (Type) <u>Melvin P. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Crem</u>	22b. DATE THEREOF <u>6-15-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u>		24a. REC'D BY REGISTRAR <u>19 61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO DEATH BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0528

06512

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston, Maryland			
f. STREET ADDRESS Box 24 - Route 2				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene Middle Fulton Last Martin				4. DATE OF DEATH Month June Day 14 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1984	
9. AGE (In years last birthday) yrs 77		10. IF UNDER 1 YEAR Months 11 Days 14 Hours 14 Min 14		11. IF UNDER 24 HRS Months 11 Days 14 Hours 14 Min 14		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) groom				10b. KIND OF BUSINESS OR INDUSTRY riding stable		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME August Martin				14. MOTHER'S MAIDEN NAME unknown Jane Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. 2-13-38-7337			
17. INFORMANT Miss Angela				Address: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 1 2 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 5, 1961 to June 14, 1961 , that (I) (we) last saw the deceased alive on June 14, 1961 , and that death occurred at 8:40 M, from the causes and on the date stated above.							
22a. SIGNATURE Loretta Hsu				22b. DATE SIGNED 6-14-61			
22c. PHYSICIAN'S NAME (Type) Loretta Hsu, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 17, 1961		23c. NAME OF CEMETERY OR CREMATORY Friends & Intimates Interment		23d. LOCATION (City, town, or county) (State) interment	
24. FUNERAL DIRECTOR'S SIGNATURE W. H. Archer				25a. REC'D BY REGISTRAR Benson		25b. REGISTRAR'S SIGNATURE Arthur L. Benson	
DATE JUN 19 1961				DATE JUN 19 1961			

424-6733



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6529

06513

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>116 N. SYMINGTON AVE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. danca before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>116 N. SYMINGTON AVE</u>	
3. NAME OF DECEASED (Type or print) <u>MAMIE</u> First <u>H.</u> Middle <u>MATHEWS</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 15, 1878</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> M.n. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>William Renicke</u>		14. MOTHER'S MAIDEN NAME <u>JORDAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Mr. Marie Jarboe - 116 N. Symington Ave.</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>1201</u> DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause next. (c) <u>Arteriosclerotic CVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u> <u>One hour</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e). <u> </u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>January 1958</u> to <u>June 4, 1961</u> , that (I) (the) last saw the deceased alive on <u>June 1, 1961</u> , and that death occurred <u>7:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James Nolan</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>L. J. NOLAN</u>		22d. ADDRESS <u>Baltimore 29, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-7-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>	23d. LOCATION (City, town or county) <u>Balto.</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederic Covington F. H. Catonsville, Md.</u>		25. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	



Reg. Dist. No. 06514

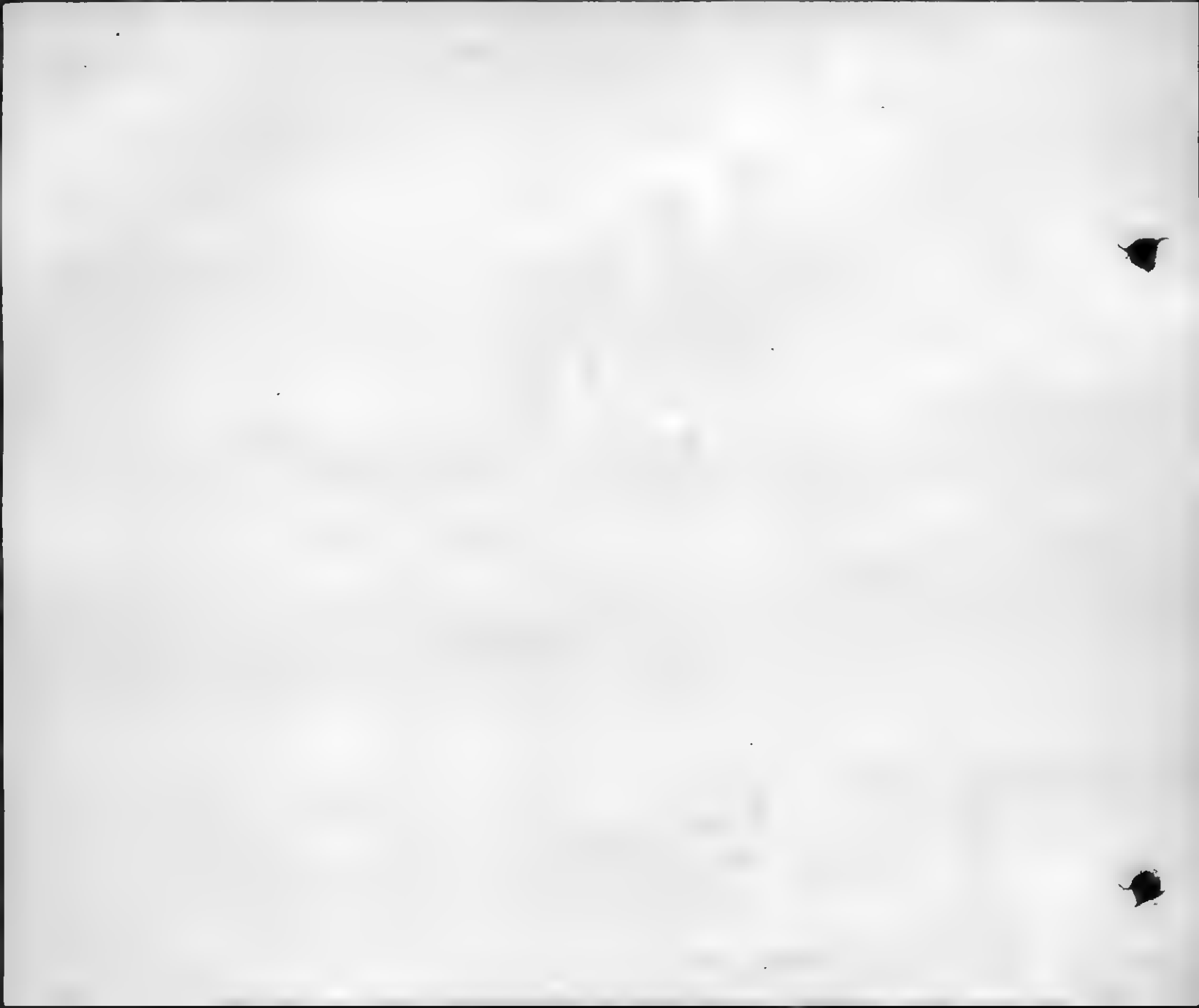
VS TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u>		b. COUNTY <u>Baltimore</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>English Counsel</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>English Counsel 27</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2723 Arbutus Ave</u>		d. STREET ADDRESS <u>2723 Arbutus Ave</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1961</u>			
3. NAME OF DECEASED (Type or print) <u>Edward L. Matthews</u>		First Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7 DEC 1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>IRON WORKER (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Jeremiah Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Price</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>41-05-0851</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic C.V.D.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>120.1</u> <u>3</u> years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic C.V.D. - Carcinoma of Larynx</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>1-2-45</u> , 19____, to <u>6-14-61</u> , 19____, that I last saw the deceased alive on <u>May 1</u> , 19 <u>61</u> , and that death occurred at <u>8?</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Nathan Raousin</u>		M.D. <u>206 S. Gilmer St.</u>		DATE SIGNED <u>6-14-61</u>			
PHYSICIAN'S NAME (Type) <u>NATHAN RAOUSIN MD</u>		Balto 23 Md					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>17 June 1961</u>		<u>Redon Park Cem</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>W. H. Walters</u>		<u>Frithy Stricker St</u>		DATE <u>JUN 16 '61</u>		<u>Arthur S. Kneass</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06515
06515

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>301</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>772 W. Hamburg St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen A</u> Middle <u>McGiff</u> Last <u>McGiff</u> 4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/29/1881</u> 9. AGE (In years last birthday) <u>79</u> yrs. 10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>61</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u> 11b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Mr Edward J. McGiff</u> Address <u>Same</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO <u>Acute & chronic</u> Conditions, if any, which gave rise to immediate cause (b) <u>Degenerative Heart Disease</u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>None</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		20c. TIME OF INJURY Month, Day, Year <u>6/12/61</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Catonsville</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/61</u> to <u>6/14/61</u> , that (I) <u>was</u> saw the deceased alive on <u>6/13/61</u> , and that death occurred <u>1207pm</u> from the causes and on the date stated above.		22a. SIGNATURE <u>W.E. McGrath</u> M.D. 22b. DATE SIGNED <u>6/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath MD</u>		22d. ADDRESS <u>1303 Frederick Rd Catonsville 28 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/17/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u> 23d. LOCATION (City, town or county) <u>Washington Rd Md.</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> ADDRESS <u>2200 E. Hill St</u> 25a. REC'D BY REGISTRAR <u>John S. Thomas</u> DATE <u>JUN 16 61</u> 25b. REGISTRAR'S SIGNATURE <u>John S. Thomas</u>	



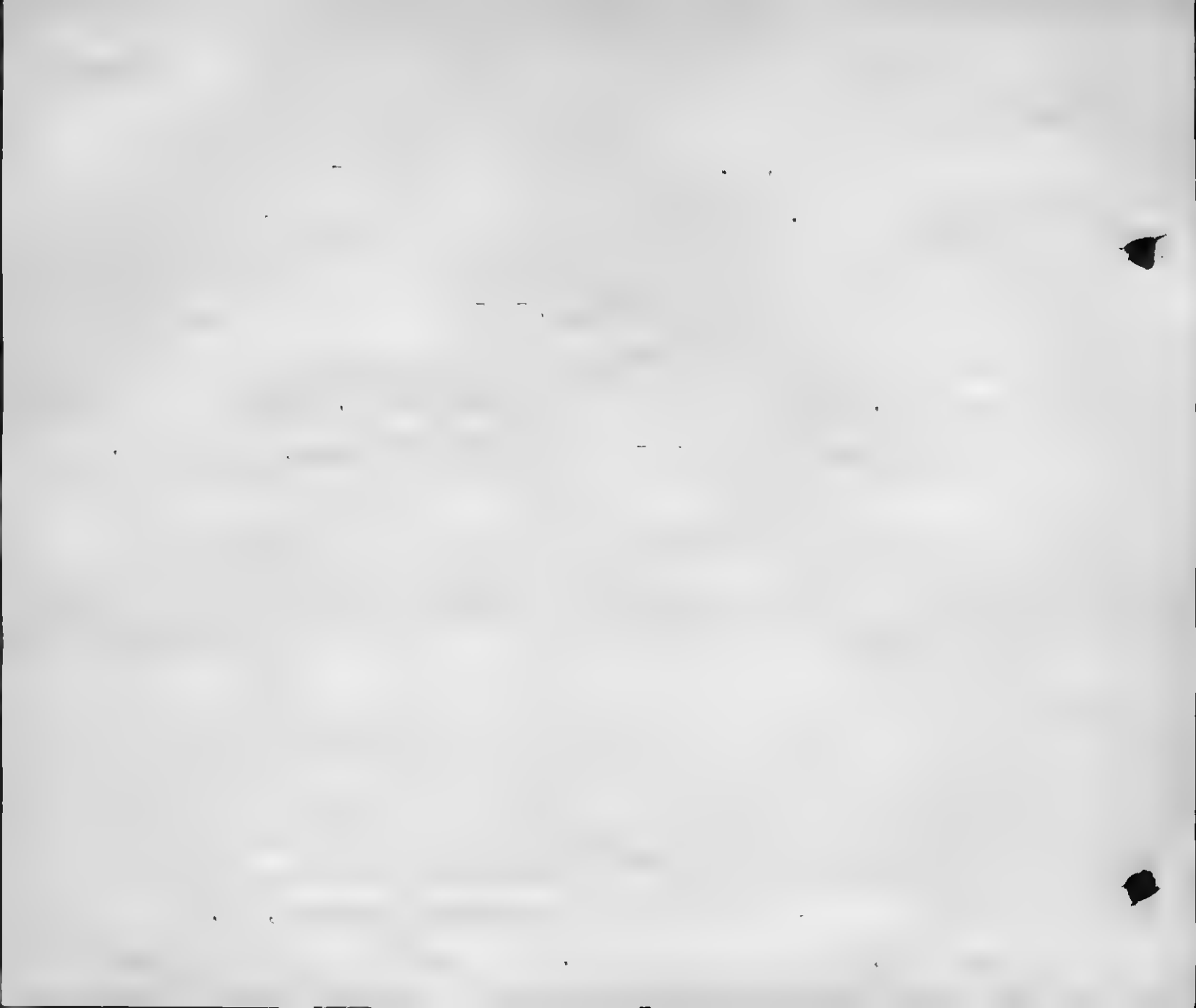
118
FIVE STATE
HEALTH DEPT.
(M)
X
(I)
MEDICAL CERTIFICATION
TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in the space provided. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C532

06516

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Dispensary</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore-24</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3004 Beverly Rd.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest Lambert</u> 4. DATE OF DEATH <u>6-5-1961</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 8. BIRTHPLACE (State or foreign country) <u>Maryland</u> 9. AGE (In years last birthday) <u>57</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. DATE OF BIRTH <u>7-23-1903</u> 13. FATHER'S NAME <u>Frank N. Meisel</u> 14. MOTHER'S MAIDEN NAME <u>Katherine E. Booker</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>217-09-9475</u> 17. INFORMANT <u>Mrs John Abbott 5507 Sefton Ave.</u> 18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (c) <u>14 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>6-5-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 22b. DATE THEREOF <u>6-8-61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery Baltimore, Md.</u> 22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR <u>Leonard J. Ruck 5305 Harford Rd.</u> 24a. REC'D BY REGISTRAR <u>JUN 7 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

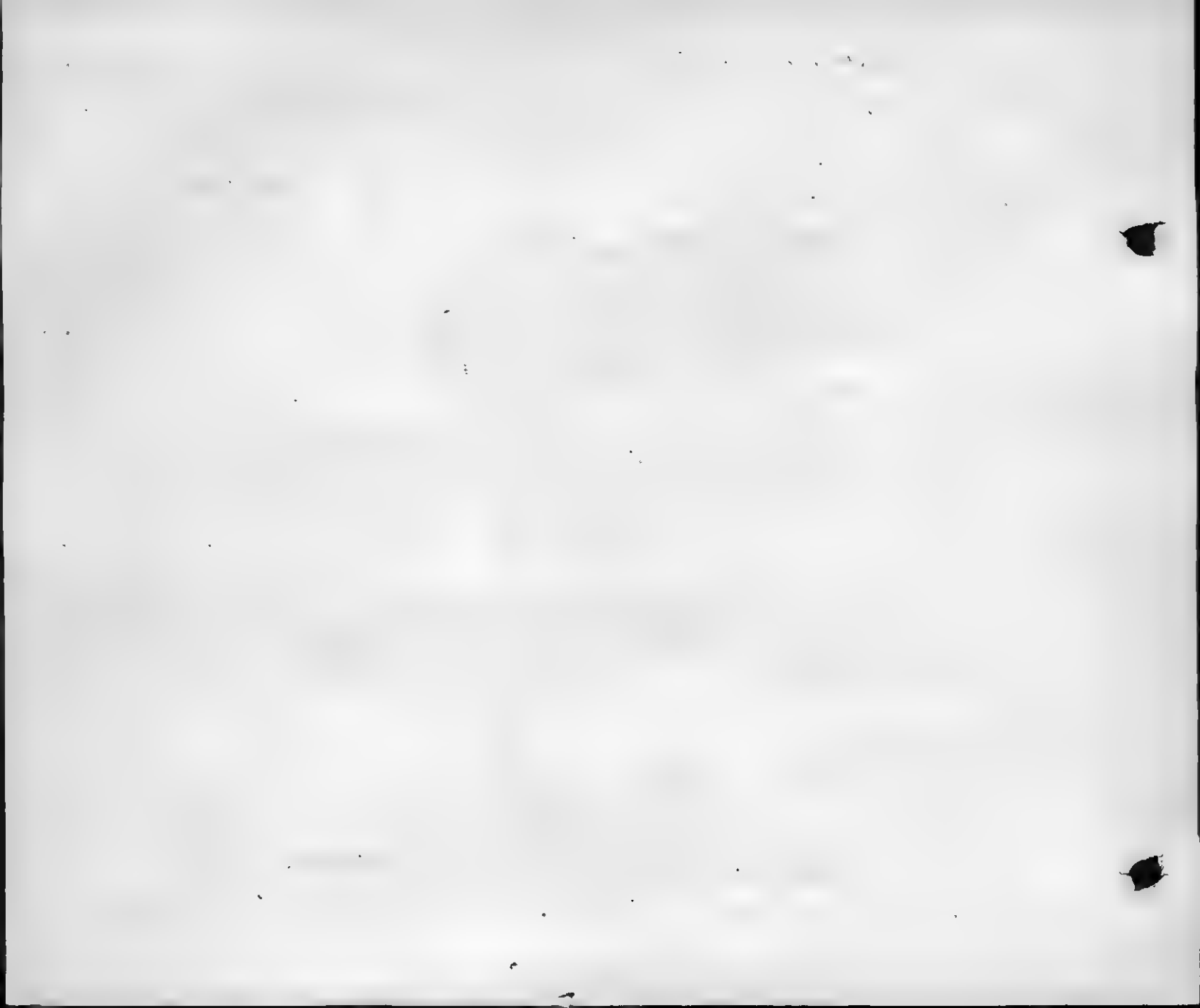
6533

06517

1. PLACE OF DEATH a. COUNTY CATONSVILLE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1222-Ingwell Drive c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2828 Ashland Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph's Nursing Home		d. STREET ADDRESS 2828 Ashland Avenue	
3. NAME OF DECEASED (Type or print) Elizabeth First Matejka Middle Michael Last		4. DATE OF DEATH Month 6 Day 22 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1883
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH STREJCZEK		14. MOTHER'S MAIDEN NAME CATHERINE PIETRIK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 210-05-4475		16. SOCIAL SECURITY NO 210-05-4475	
17. INFORMANT Alfred Michael - Catone		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 wk 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/28/61 to 6/22/61 , 19____, that (I) (we) last saw the deceased alive on 6/22/61 , 19____, and that death occurred at 5 pm from the causes and on the date stated above			
22a. SIGNATURE J. E. Rowe		22b. DATE SIGNED 6/22/61	
22c. PHYSICIAN'S NAME (Type) James E. Rowe		22d. ADDRESS 1011 Frederick Rd. 28-Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-26-61	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City, town or county) (State) Baltimore Md
24. FUNERAL DIRECTOR'S SIGNATURE Coach Funeral Home, Inc. E.S.		25a. REC'D BY REGISTRAR JUN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Haines			

M

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

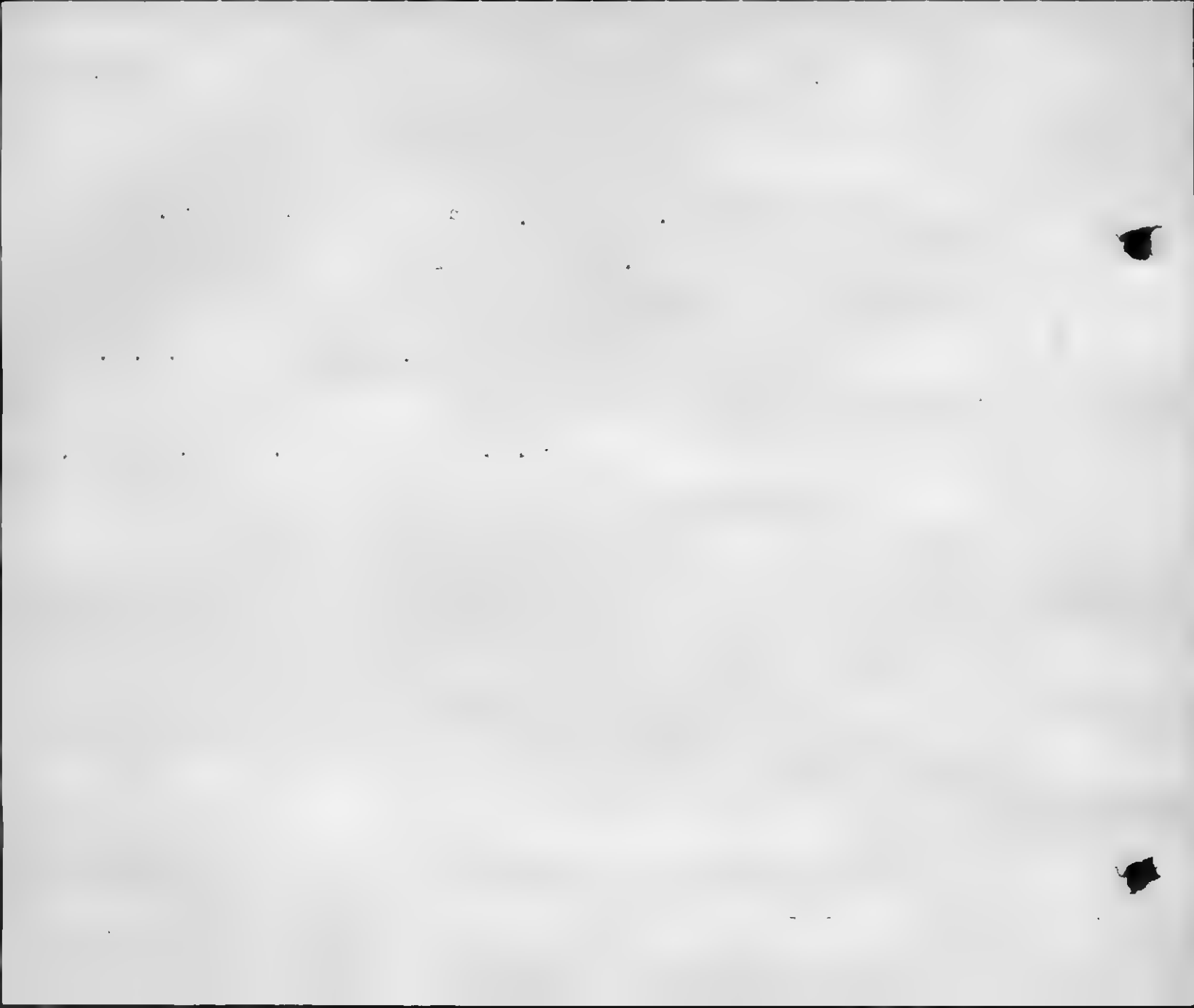
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6534

06518

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shady Nook Nursing Home 1002 N. Rolling Rd. Formerly of 3800 Calloway Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3V</u>	
3. NAME OF (Type or print) <u>Elsie</u> <u>B.</u> <u>Mitchell</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1882</u>	
9. AGE (in years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>25</u> Days <u>19</u> Hours <u>61</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
14. FATHER'S NAME <u>Millard Burrier</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>no</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE -</u> DUE TO <u>CEREBRAL THROMBOSIS -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>NO BERN INCLINUS</u> DUE TO <u>NO BERN INCLINUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>no</u>	
21. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5800 EDMONSON AVE BALTIMORE MD</u>		24. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>Maryland</u>	
25. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>58</u> to <u>6/25</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> 19 <u>61</u> , and that death occurred at <u>6:10 PM</u> from the causes and on the date stated above.			
26a. SIGNATURE <u>John H. Shaw M.D.</u>		26b. DATE SIGNED <u>6/26/61</u>	
27a. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		27b. ADDRESS <u>5800 EDMONSON AVE BALTIMORE MD</u>	
28a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		28b. DATE THEREOF <u>6-28-61</u>	
29a. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		29b. LOCATION (City, town or county) <u>Baltimore Maryland</u> (State) <u>Maryland</u>	
30. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. J. Lickner</u>		31. ADDRESS <u>North - Pa. Bldg.</u>	
32. REC'D BY REGISTRAR <u>DATE JUN 27 '61</u>		33. REGISTRAR'S SIGNATURE <u>James S. Smith</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

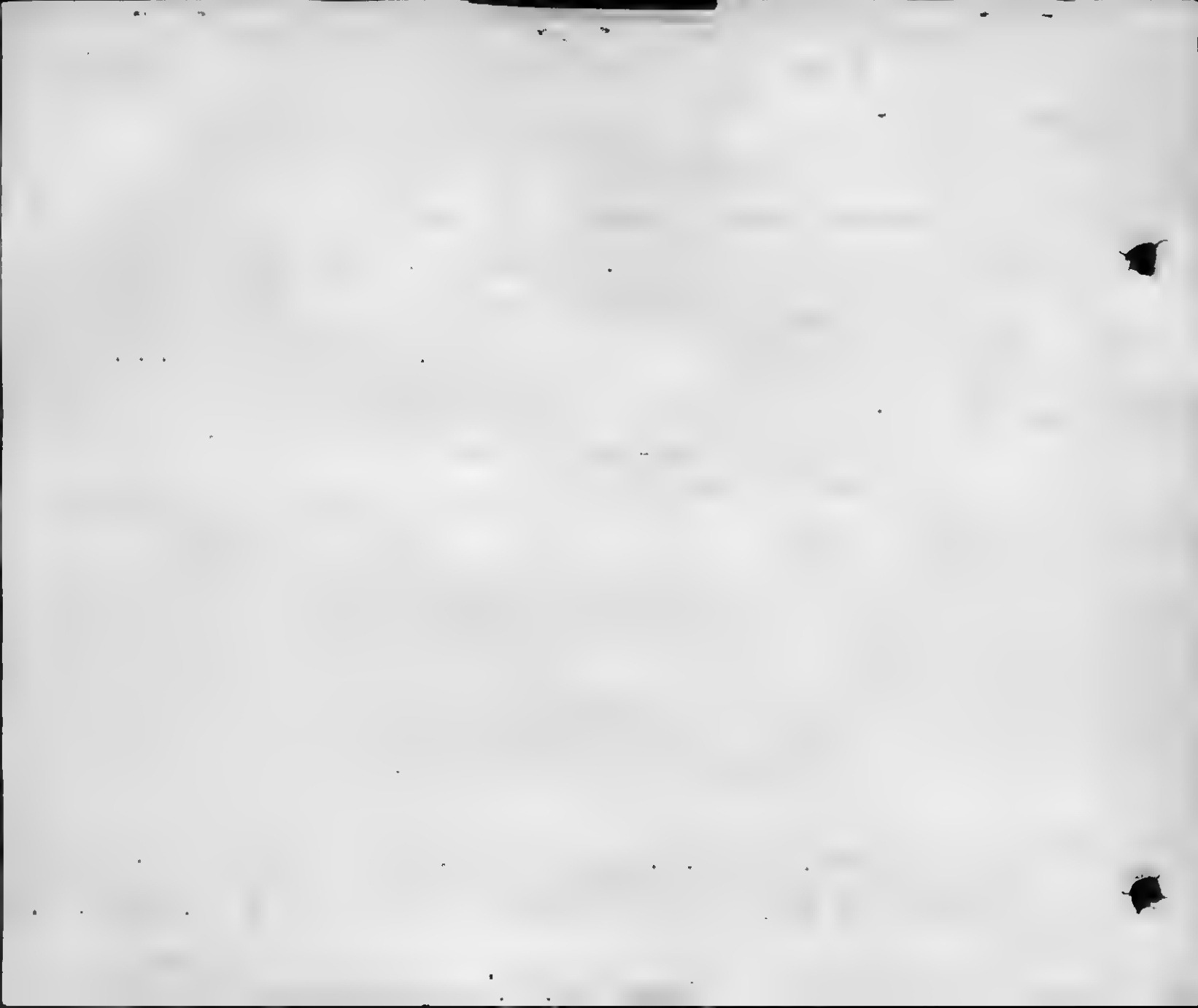
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06519

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT HOWARD</u> c. LENGTH OF STAY IN 1b <u>103 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>535 Hampton Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE W. MURRAY, SR.</u> First Middle Last		4. DATE OF DEATH <u>June 3 1961</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1897</u> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u> 10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Texas, Maryland</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Murray</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Parks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>216-05-6998</u> 17. INFORMANT <u>CLINICAL RECORDS, VAH, BALTIMORE, MD.</u> <u>FT HOWARD DIVISION</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANAPLASTIC CARCINOMA OF RIGHT BRONCHUS</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month. Day. Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ 20g. (County) _____ 20h. (State) _____		21. I certify that (X) (this hospital) attended the deceased from <u>February 20, 1961</u> to <u>June 3, 1961</u> that (X) (we) last saw the deceased alive on <u>June 3, 1961</u> , and that death occurred at <u>1:24 AM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Norman P. Jones, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>NORMAN P. JONES, M. D.</u>		22b. DATE SIGNED <u>6/3/61</u> 22d. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIV.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>BURIAL 6-6-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town or county) <u>Balto 14, Md.</u> 23e. REC'D BY REGISTRAR <u>June 7 '61</u> 23f. REGISTRAR'S SIGNATURE <u>Charles L. Hanna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Bright Funeral Home, 6009 Harford Rd. Baltimore, Md.</u>			



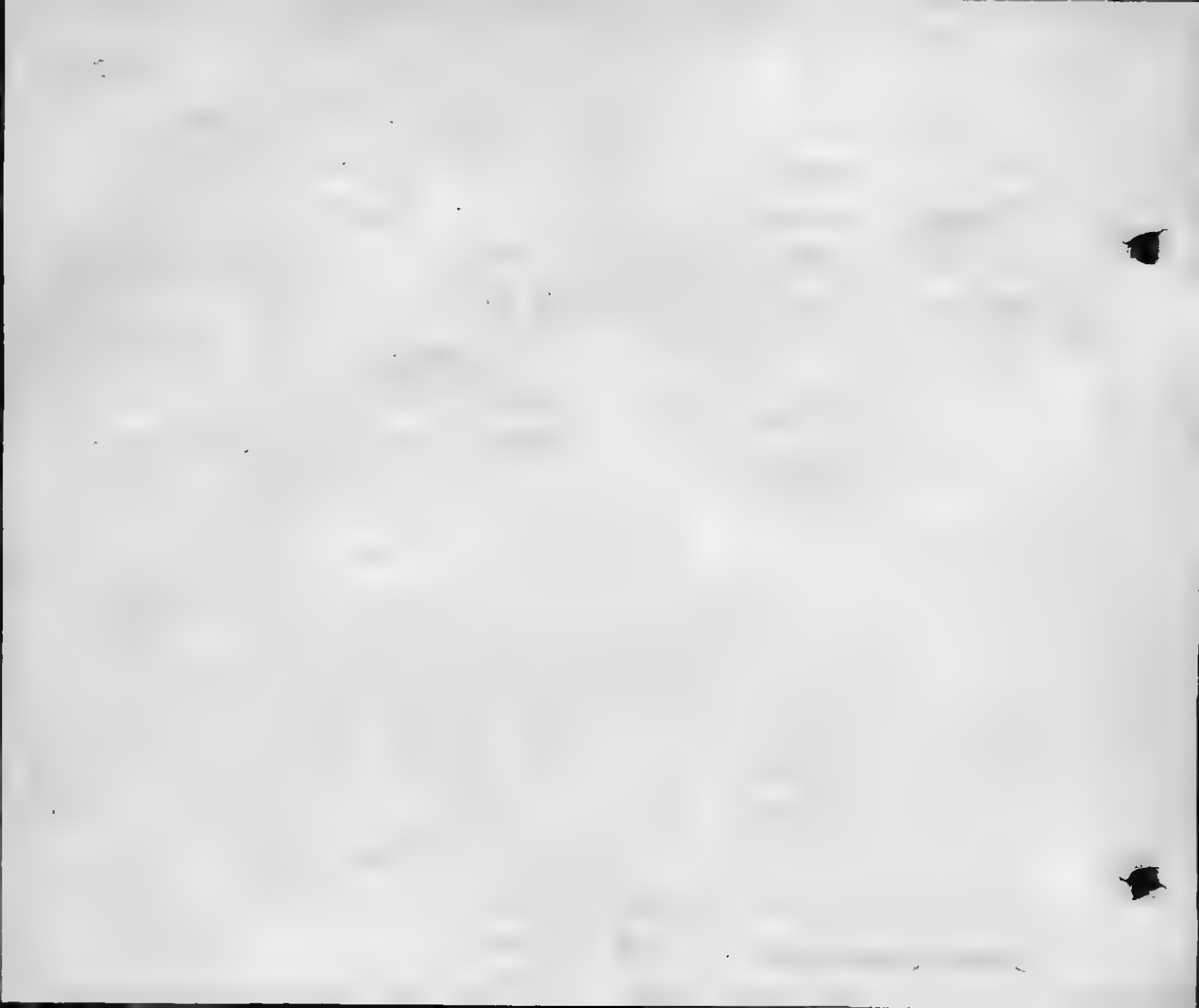
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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6536
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06520

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foley's Conv. Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5400 Lynview Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>7</u> Last <u>MYERS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1883</u>	
9. AGE (In years last birthday) <u>77 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russian</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>624-60-1234</u>	
17. INFORMANT <u>Harvey Myers</u>		Address <u>624 1/2 Fremont</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral + Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Deaths Mellitus</u> DUE TO (b) <u>260X</u> DUE TO (c) <u>260X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> <u>6/16/61</u> to <u>6/2/61</u> 19 , that (I) (we) last saw the deceased alive on <u>6/16/61</u> 19 , and that death occurred at <u>6A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Melvin Skunkin</u> M.D.		22b. DATE SIGNED <u>6/2/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>2320 Eutaw Place</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-2-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Kurose</u>		25a. REC'D BY REGISTRAR <u>2000 Eutaw Place</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>		DATE <u>JUN 5 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

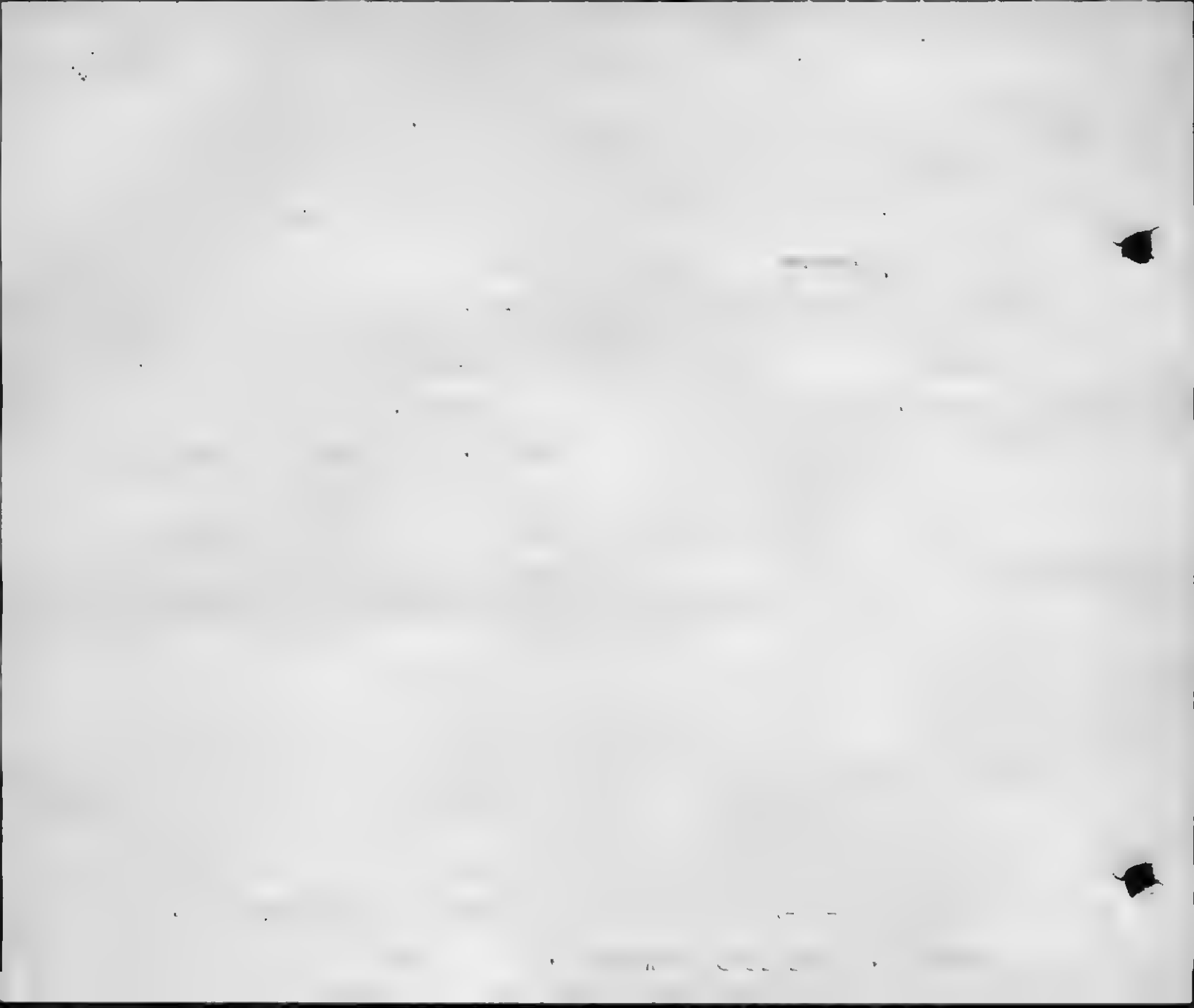
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
6537									
06521									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>405 Dixie Drive</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>405 Dixie Drive</u>				
3. NAME OF DECEASED (Type or print) <u>Mamye</u> First <u>Nied</u> Middle <u>Nied</u> Last <u>Nied</u>					4. DATE OF DEATH <u>6</u> Month <u>17</u> Day <u>1961</u> Year				
5. SEX <u>female</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>10-11-1884</u>				
9. AGE (In years last birthday) <u>76</u> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>John T. Bevan</u>					14. MOTHER'S MAIDEN NAME <u>Mary R.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>Harry B. Nied</u>				
17. INFORMANT <u>same</u>					Address <u>same</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>Arteriosclerotic cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1926</u> to <u>June 17, 1961</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>6-10-1961</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>John J. Gould</u> M.D.									
22b. DATE SIGNED <u>6-17-61</u>									
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. GOULD</u>									
22d. ADDRESS <u>1421 Eastport - 24</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>									
23b. DATE THEREOF <u>6-20-1961</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>									
23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>									
25a. REC'D BY REGISTRAR <u>JUN 20 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06522

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>5 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shadybrook Home</i>		1 d. STREET ADDRESS <i>Cherrydale Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Katherine Marie Opel</i>		4. DATE OF DEATH Month <i>6</i> Day <i>17</i> Year <i>1961</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-12-1875</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11 BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>August Opel</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Klein</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i> (If yes, give war or dates of service) <i></i>		16 SOCIAL SECURITY NO. <i></i>	
17 INFORMANT <i>Mrs. Medred E. Smith - White Marsh - Md</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Ischemic Necrosis</i> DUE TO <i>420.1</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary atherosclerosis</i> DUE TO <i>103.1</i> (c) <i>Generalized arteriosclerosis</i> DUE TO <i>103.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-204</i> <i>103.1</i> <i>103.1</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21 I certify that (I) (this hospital) attended the deceased from <i>10-16</i> 19 <i>60</i> to <i>6-17</i> 19 <i>61</i> , that (I) (<i>ma</i>) last saw the deceased alive on <i>6-17</i> 19 <i>61</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Wilmer K. Gallagher</i>		22b. DATE SIGNED <i></i>	
22c. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>		22d. ADDRESS <i>6309 Frederick Rd, Baltimore, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-20-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		23d. LOCATION (City or town, or county) (State) <i>Baltimore Md</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Edw. J. [illegible]</i>		25a. REC'D BY REGISTRAR <i>JUN 21 1961</i>	
ADDRESS <i>Catonsville - 78 - Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. [illegible]</i>	

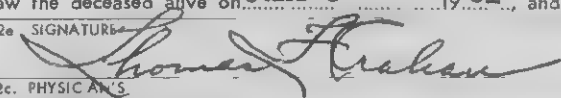



MARYLAND STATE DEPARTMENT OF HEALTH

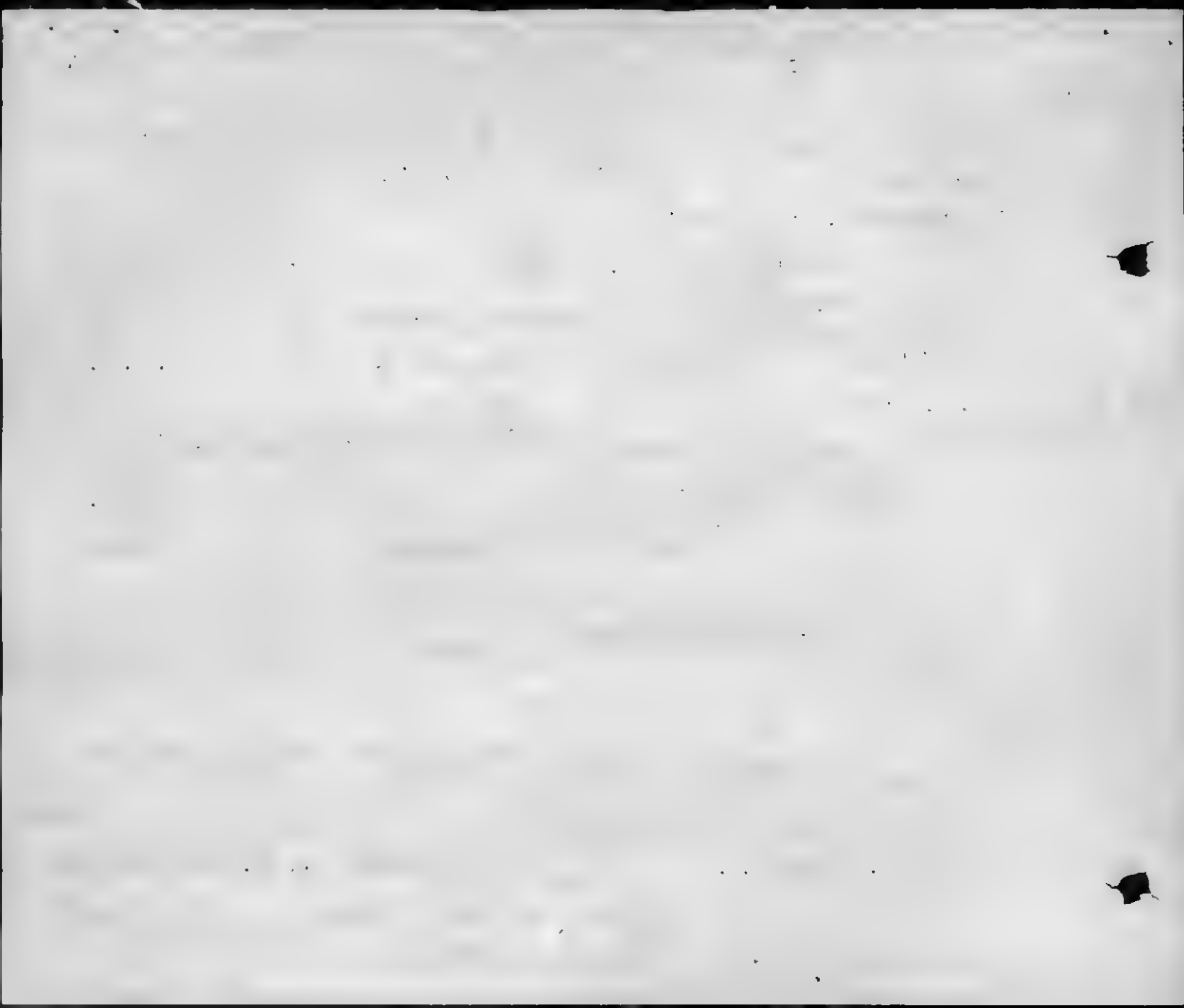
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6539

66523

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland				b. COUNTY Queen Annes			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY in 1b 22 Days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Centreville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital								d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) WALTON				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> C. ORRELL			
5. SEX Male				8. DATE OF BIRTH October 26, 1889				9. AGE (In years last birthday) 71 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tax-Collector				10b. KIND OF BUSINESS OR INDUSTRY INCOME TAX				11. BIRTHPLACE (County & State, or foreign country) Chestertown, Maryland			
13. FATHER'S NAME W. C. Orrell				14. MOTHER'S MAIDEN NAME Core Story				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of discharge) Yes WW I				16. SOCIAL SECURITY NO. 214-03-3917				17. INFORMANT Clinical Records, VAH, Baltimore, Maryland Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO MYOCARDIAL INFARCT Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC HEART DISEASE (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH 3 MIN. RECENT UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema. Tumor, left lung.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that 10 (this hospital) attended the deceased from May 15, 1961 , to June 6, 1961 , that 10 (we) last saw the deceased alive on June 6, 1961 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE 				22b. DATE 6/11/61				22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial JUNE 9-1961				23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial				23d. LOCATION (City, town or county) (State) Routess m. Eastern Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE 				25a. REC'D BY REGISTRAR DATE JUN 13 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1
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 MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filled within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If my delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6540

06524

Item 22 Film G-90 7/12/61 jwk

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN TB 15 min.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Carroll		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Westmoreland Street		d. STREET ADDRESS Westminster		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RALPH STERLING OSTERHUS		4. DATE OF DEATH June 23 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1916		9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F2H		10b. KIND OF BUSINESS OR INDUSTRY Congoleum Nairn Inc		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Osterhus		14. MOTHER'S MAIDEN NAME Grace Gallaway		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 217-03-4541	
17. INFORMANT Congoleum Nairn Inc. Records- Cedarhurst, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		20c. TIME OF INJURY Month, Day, Year none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none		20g. (County) none		20h. (State) none		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-23-61	
ACTUAL SIGNATURE D. D. Caples		EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd. Reisterstown, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 26, 1961		22c. NAME OF CEMETERY OR CREMATORY Carrollton Church of God		22d. LOCATION (City, town, or country) Rural-westminster, Md.		22e. REGISTRAR'S SIGNATURE Arthur S. Huns	
22f. REGISTRAR'S SIGNATURE		22g. REGISTRAR'S SIGNATURE		22h. REGISTRAR'S SIGNATURE		22i. REGISTRAR'S SIGNATURE		22j. REGISTRAR'S SIGNATURE		22k. REGISTRAR'S SIGNATURE		22l. REGISTRAR'S SIGNATURE		22m. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

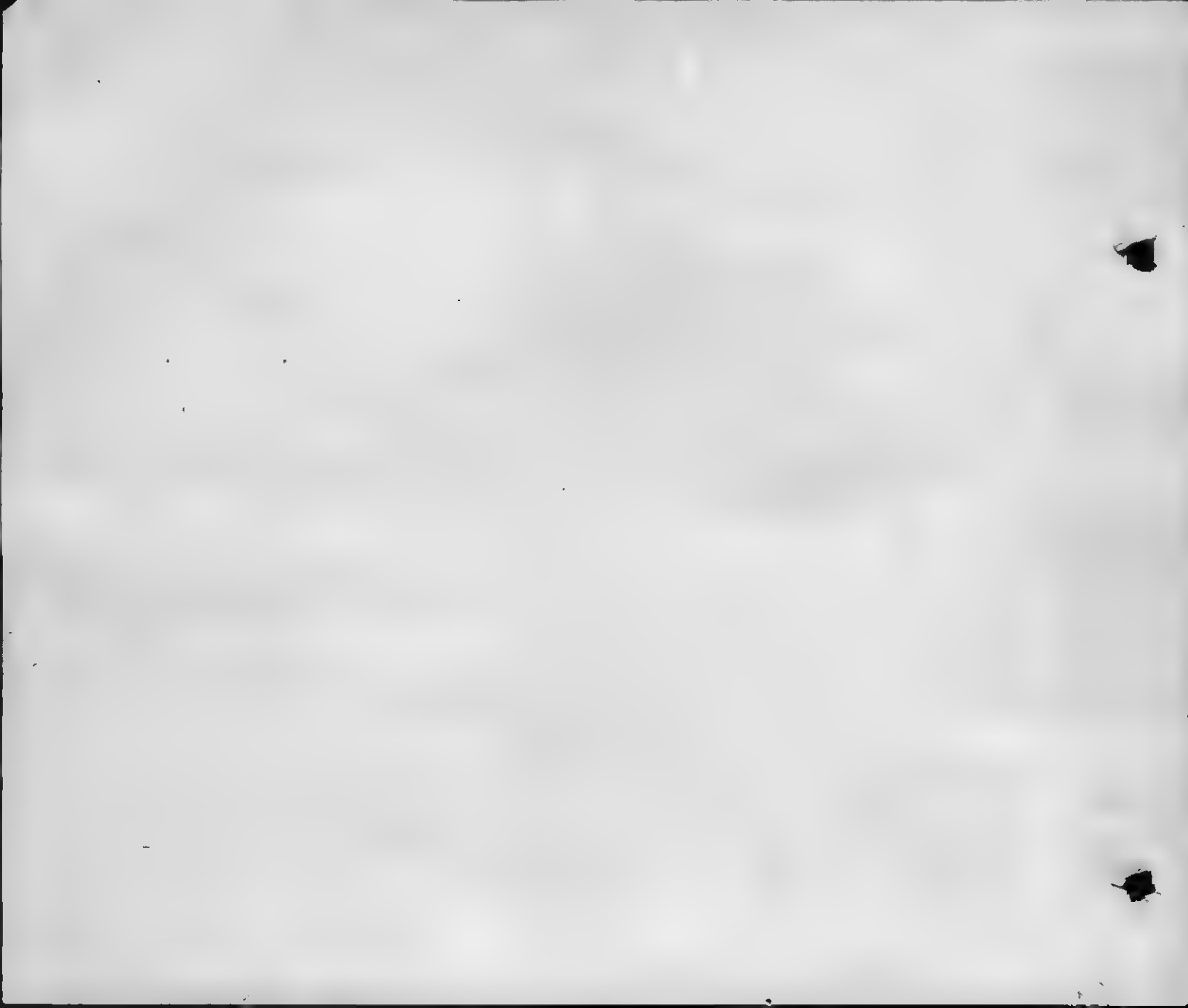
ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Myers Funeral Home, Willis St. & Longwell, Westminster, Md.

JUN 29 '61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6541

06525

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>6 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>107 LOCUST DR.</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>107 LOCUST DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DOUGLAS S. OTTERSON</u> First Middle Last		4. DATE OF DEATH <u>6/8/1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/04</u> 156 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Tool Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.Y. N.Y.</u>	
13. FATHER'S NAME <u>WM. C. OTTERSON</u>		14. MOTHER'S MAIDEN NAME <u>DUMAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Paige Ottersen</u> Address _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INSUFFICIENCY</u> 442 X Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardiovascular Disease at least 5 years</u> (c) <u>Arteriosclerotic Vascular Disease</u> 7 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC ASTHMATIC BRONCHITIS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 23, 1956</u> , to <u>June 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 1, 1961</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Melvin N. Borden</u> 22c. PHYSICIAN'S NAME (Type) <u>Melvin N. BORDEN</u>		22b. DATE SIGNED <u>6/9/61</u> 22d. ADDRESS <u>5000 BALTO. NATIONAL PIKE BALTO 29 MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>6/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Toulon Park</u>		23d. LOCATION (City, town or county) <u>Baltimore Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Haff & Son 28</u> ADDRESS _____		25a. REC'D BY REGISTRAR <u>DATE JUN 12 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

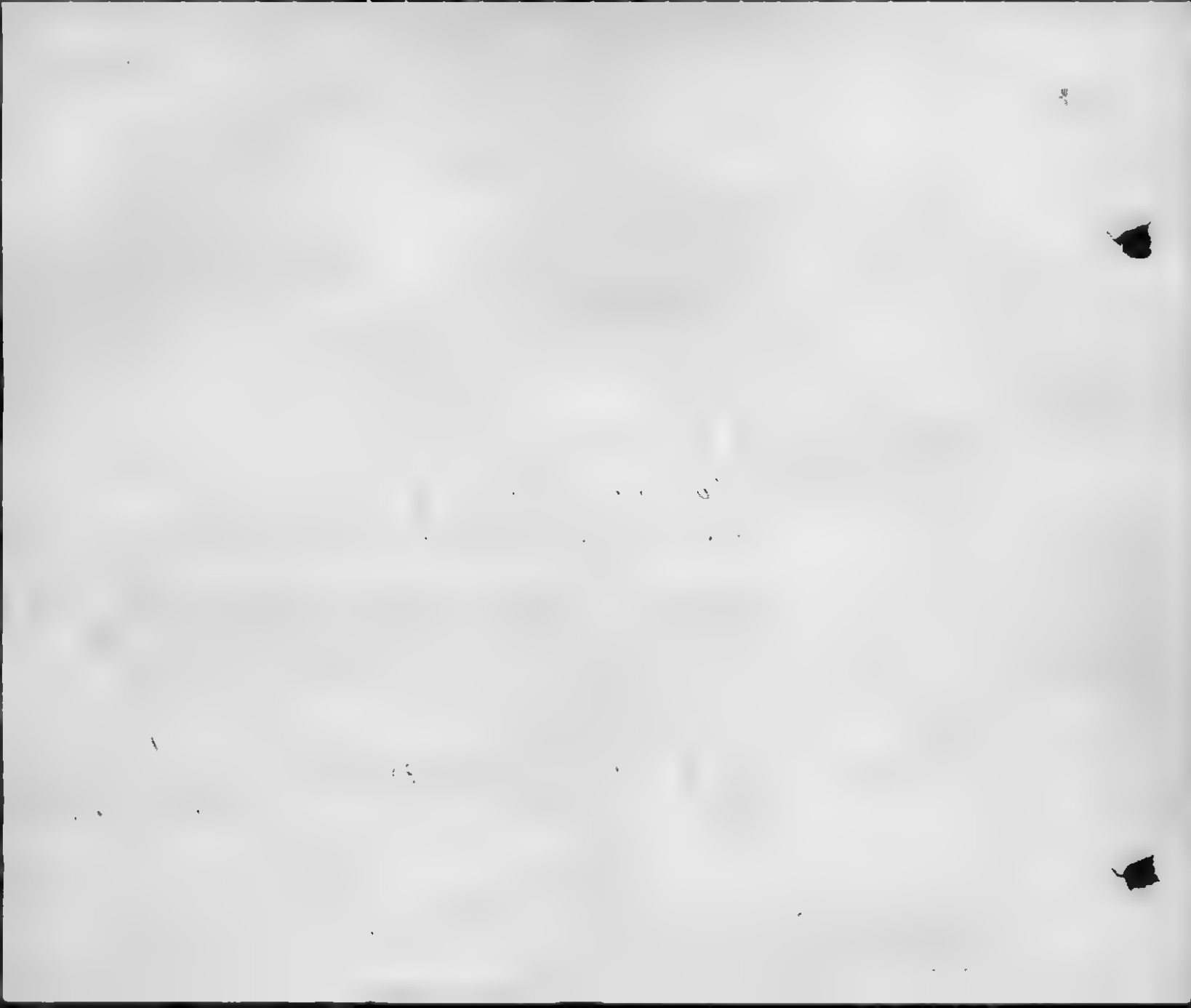
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6542

06526

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 mth 26dys</u>		d. STREET ADDRESS <u>30 South Pulaski Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles</u> <u>Pall</u>		4. DATE OF DEATH Month Day Year <u>June</u> <u>20</u> <u>19 61</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>Widowed</u>		8. DATE OF BIRTH <u>1901, March 3</u>	
9. AGE (In years last birthday) <u>60 yrs.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> <u>unknown</u>		16. SOCIAL SECURITY NO. <u>196-01-8400</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 22.1 DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a, b, c)		19. V. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 8</u> , 19 <u>61</u> , to <u>June 20</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 20</u> , 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jose R. Arizaga</u>		22b. DATE SIGNED <u>June 20, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-23-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Miller</u>		25a. REC'D BY REGISTRAR <u>JUN 22 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			



CERTIFICATE OF DEATH

Reg. Dist. No.

06527

6543

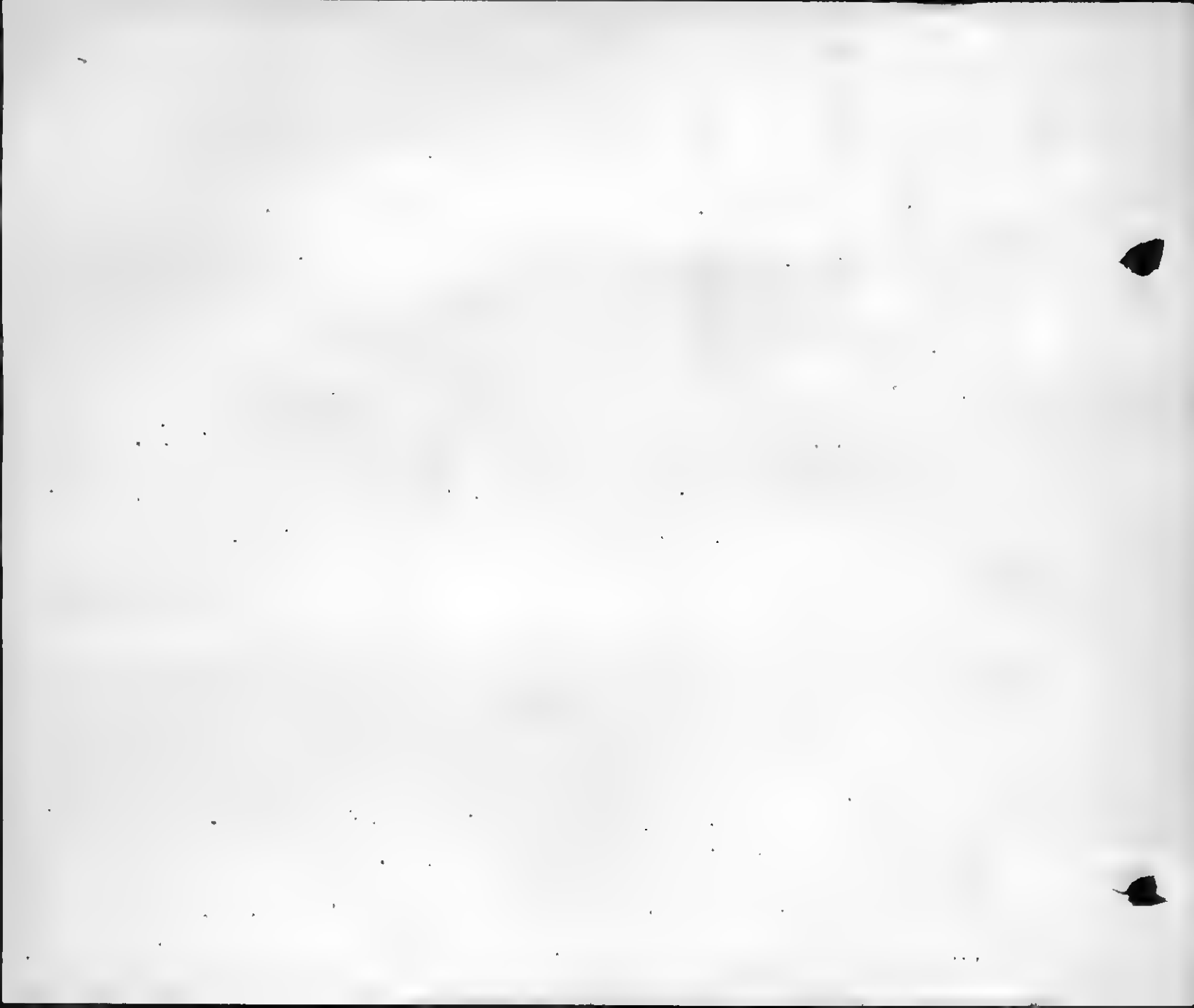
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>103 Frederick Ave.</u>		d. STREET ADDRESS <u>103 Frederick Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bennett Brown Parks</u> Middle Last		4. DATE OF DEATH June 16 19 61	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/8/05</u>
9. AGE (In years last birthday) yrs. <u>55</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Customs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edgar Parks</u>		14 MOTHER'S MAIDEN NAME <u>Irene Schinberg</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.II</u>		16 SOCIAL SECURITY NO. <u>? 216-10-8788</u>	
INFORMANT <u>6103 Frederick Ave, Mrs Hazel Parks Catonsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-11-1952</u> to <u>6-16-1961</u> , that I last saw the deceased alive on <u>6-16-1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6-16-61</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore-Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b DATE THEREOF <u>6/20/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 21 '61</u>	
ADDRESS <u>Ellicott City, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. Delay is necessary. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06528

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7 WILLOW AVE		d. STREET ADDRESS 7 WILLOW AVE	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HERBERT Last PETERSON		4. DATE OF DEATH Month JUNE Day 26 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Deliveryman		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Thomas Peterson		14. MOTHER'S MAIDEN NAME Mary Florence Torbit	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 125-42-5962	
17. INFORMANT Family Records		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND, CALVARIUM DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) MENTAL DEPRESSION			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William A. Pillsbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Timonius Md.		DATE SIGNED 6/26/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1961	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or country) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE JUL 5 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Andrew S. Kline	

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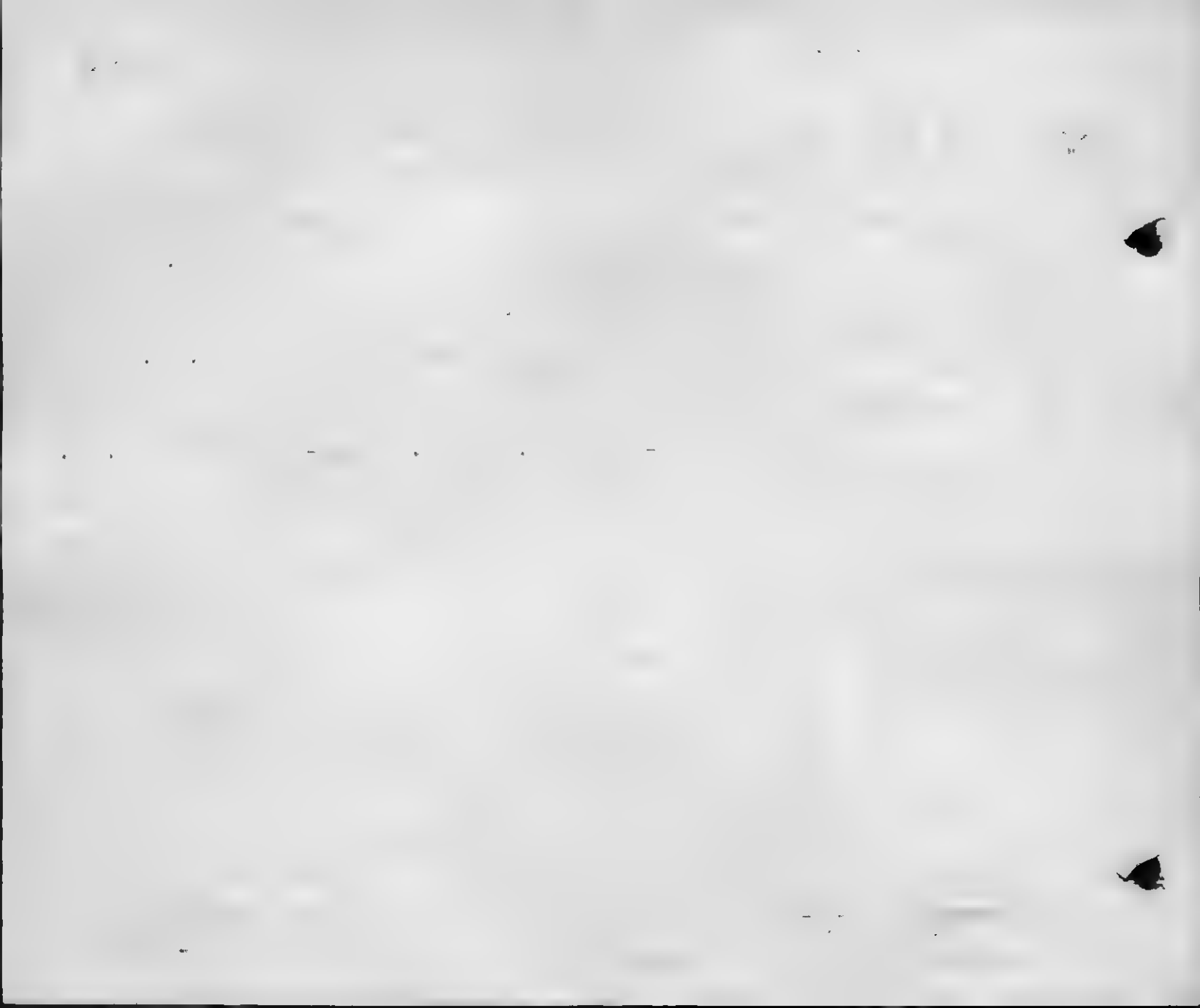
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
6545 CERTIFICATE OF DEATH 06529									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (Overlea) c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10 Fullerton Heights Avenue</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (Overlea) d. STREET ADDRESS <u>10 Fullerton Heights Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Edgar Clayton Philipp</u> First Middle Last 4. DATE OF DEATH <u>June 19, 1961</u> Month Day Year					9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Mar. 19, 1887</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Henry Philipp</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Lentz</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>213-10-7091</u> 17. INFORMANT <u>Mrs. Edgar C. Philipp-10 Fullerton Hts. Ave.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis & infarction</u> DUE TO (b) <u>Accelerated Atherosclerosis</u> DUE TO (c) <u>Ch. Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>7-2-51</u> <u>1 year</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7-2-1961</u> to <u>June 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 19, 1961</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>GEO. MCLEAN</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>705 Medco Bldg - 1 - Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>			23b. DATE THEREOF <u>6-23-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Towson, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>North & Vienna Aves. Baltimore 17, Md.</u>					25a. REC'D BY REGISTRAR <u>JUN 21 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06530

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eccleston</i>		c. LENGTH OF STAY IN TOWN <i>10 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Burnside Farms</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edwin Wingate Poe</i>		4. DATE OF DEATH Month <i>June</i> Day <i>22</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 13, 1876</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Banker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Louisville, Ky.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Poe</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Graham Wingate</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. ADDRESS <i>Mrs Miniam Poe Baetjer Owings Mills, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 422.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>15 years</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1952</i> to <i>June 22, 1961</i> , that I lost s/he the deceased alive on <i>22 June, 1961</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Paul H Royse M.D. 1403 Foley Lane June 22, 1961</i>			
ACTUAL SIGNATURE <i>Paul H Royse</i>		PHYSICIAN'S NAME (Type) <i>Paul H Royse Pikesville 8 Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation June 22, 1961</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons Co. 4905 York Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 26 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



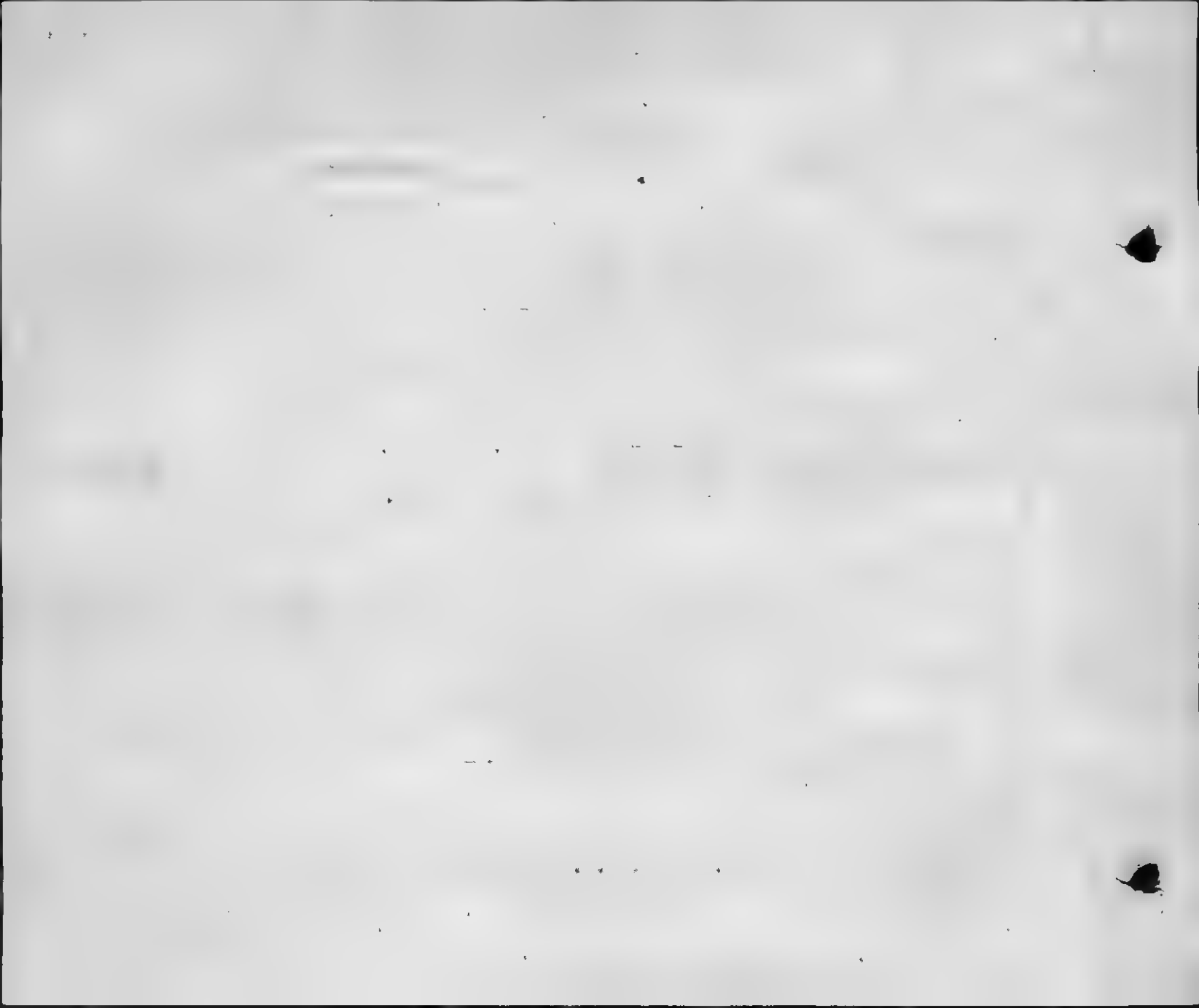
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6547
6531

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville c. LENGTH OF STAY IN 1b Parkville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7806 Ardmore Avenue				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville d. STREET ADDRESS 7806 Ardmore Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREDERICK EUGENE POLANCO		4. DATE OF DEATH Month June Day 3 Year 1961					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1896	9. AGE (in years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6 Days 19 Hours 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dominican Republic			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Eugene Polanco		14. MOTHER'S MAIDEN NAME Aurelia Payan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 220-07-1465		16. SOCIAL SECURITY NO. 220-07-1465		17. INFORMANT Mrs. Mary C. Polanco Address same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 720.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/3/61			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county) Baltimore, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6/6/61	22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.	22d. LOCATION (City, town, or country) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Road.		24a. REC'D BY REGISTRAR DATE JUN 5 '61 24b. REGISTRAR'S SIGNATURE Charles S. Petty					

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 of this Medical Examiner's Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

06532

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stevenson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stevenson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hillside ave</i>		d. STREET ADDRESS <i>1 Hillside ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alexander Hamilton S. Post</i>		4. DATE OF DEATH <i>June 5 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 6, 1870</i>
9. AGE (In years last birthday) <i>90</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Merchantile-Safe Deposit and Trust Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Stevenson, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard Bayley Post</i>		14. MOTHER'S MAIDEN NAME <i>Ella Stump</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-16-3125</i>	
17. INFORMANT <i>Butler Road</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <i>351X Cerebral vascular accident with left hemiplegia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>351X</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> to <i>5 June 1961</i> , that I last saw the deceased alive on <i>5 June 1961</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H. Royse</i>		ADDRESS (Street, city or town, state) <i>1403 Foley Lane</i>	
DATE SIGNED <i>5 June 61</i>			
PHYSICIAN'S NAME (Type) <i>Paul H. Royse</i>		<i>Pikesville 8 Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 7, 1961</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>St Thomas Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Garrison Forest Balto Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons Co.</i>		ADDRESS <i>4905 York Road</i>	
24a. REC'D BY REGISTRAR <i>JUN 7 61</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. L. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6543

CERTIFICATE OF DEATH

Reg. Dist. No. 06533

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6919 Ridgeway Road				d. STREET ADDRESS 6919 Ridgeway Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HENRY WILLIAM POWELL				4. DATE OF DEATH Month Day Year June 30th, 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1898	
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Powell				14. MOTHER'S MAIDEN NAME Bette Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-07-7234		17. INFORMANT Pansy B. Powell Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 44X DUE TO (b) Hypertensive Cardiovascular de Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 19 51 , to 6-30 19 61 , that I last saw the deceased alive on 6-25 19 61 , and that death occurred at 8:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 Kinship Road DATE SIGNED 7/3/61 ACTUAL SIGNATURE Jack C. Collins M.D. Jack C. Collins, M.D. Baltimore 22, Maryland PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/61		22c. NAME OF CEMETERY OR CREMATORY Gentryes Cemetery		22d. LOCATION (City, town, or county) (State) Boonesville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REC'D BY REGISTRAR DATE JUL 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6550

06534

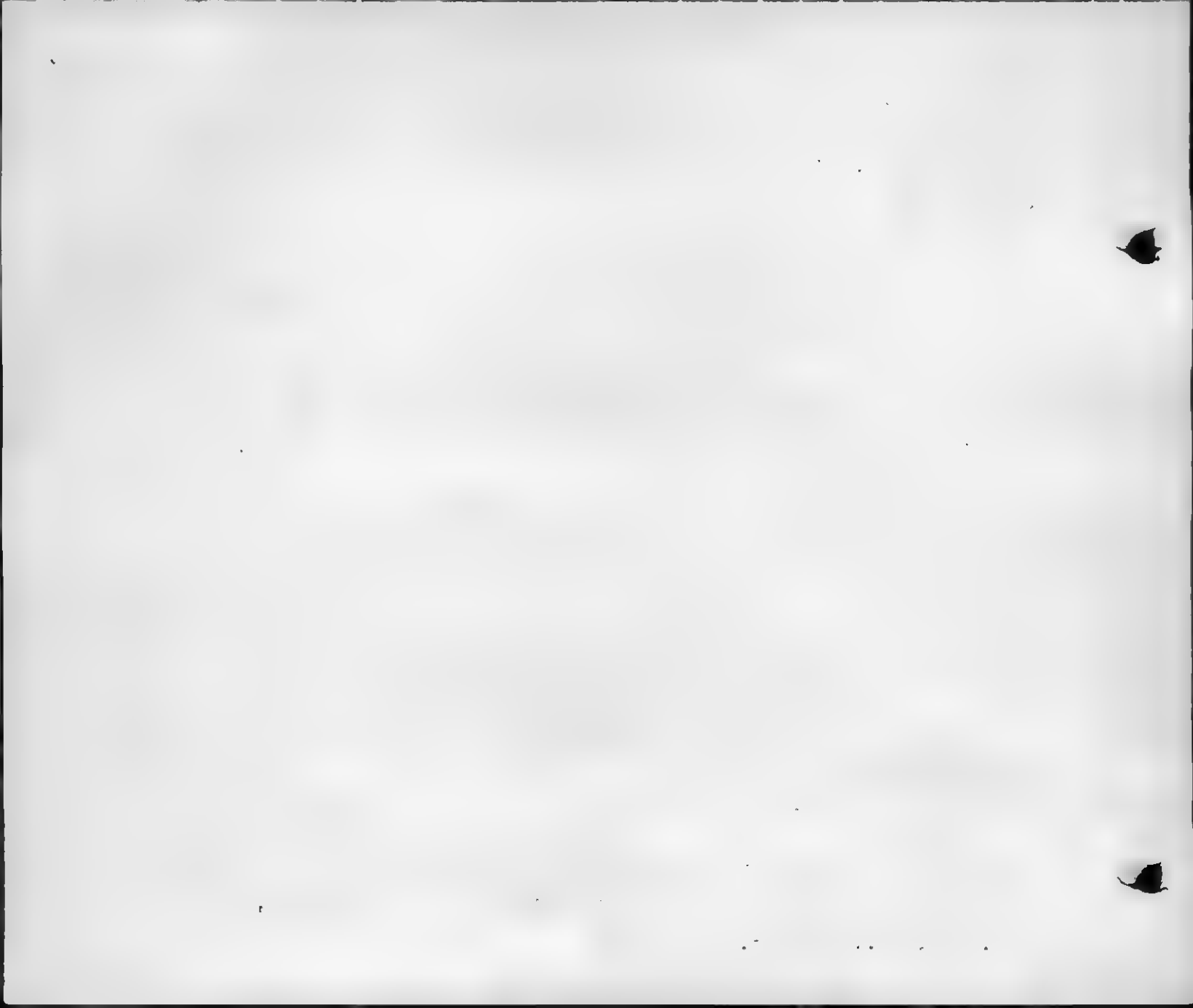
1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u> c. LENGTH OF STAY IN 1b <u>3 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MASONIC HOME</u>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Not set</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HOLLAND PRICE</u>			4. DATE OF DEATH Month Day Year <u>JUNE 11 1961</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1869</u>	9. AGE (In years last birth day) <u>91</u> - yrs.	IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CYSTER BUSINESS</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>GIDEON PRICE</u>				
14. MOTHER'S MAIDEN NAME <u>ANNA ADAMS</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT Address <u>Frank L. Smith Jr. - Cockeysville, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissection</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19____		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State) <u>STOCKTON, MARYLAND</u>					21. I certify that (I) (this hospital) attended the deceased from <u>7-2</u> <u>1961</u> to <u>6-9</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>6-9</u> <u>1961</u> and that death occurred at <u>1:25 P</u> from the causes and on the date stated above.		
22a. SIGNATURE <u>Walter T. Kees</u>					22b. DATE SIGNED <u>6/11/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>					22d. ADDRESS <u>COCKEYSVILLE, MD</u>		
23a. BURIAL CREMATION, etc. (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-14-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gunby Presbyterian</u>			
23d. LOCATION (City, town, or county) (State) <u>Stockton, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook, Inc., 1217 St. Paul Street</u>					
25a. REC'D BY REGISTRAR DATE <u>JUN 13 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

M

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MEDICAL CERTIFICATION

44



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06535**

C551

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) 3403 Gata Cuba Drive		d. STREET ADDRESS 3403 Gata Cuba Drive	
3. NAME OF DECEASED (Type or print) Anna First Rabinowitz Middle L Last		4. DATE OF DEATH 6-3-1961 Month 6 Day 3 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 60 yrs.
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 3 Hours 1 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aaron Friedmann		14. MOTHER'S MAIDEN NAME Jennie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Philip Rabinowitz Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Malignant Tumor 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5-months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 15, 1961 to Jun 3, 1961 , that I last saw the deceased alive on June 3, 1961 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Herman Seidel M.D.		ADDRESS (Street, city or town, state) 2404 Euterpe Pl, Baltimore, Md.	
PHYSICIAN'S NAME (Type) HERMAN SEIDEL		DATE SIGNED 6/4/61	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-4-61	22c. NAME OF CEMETERY OR CREMATORY Rosedale	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis ADDRESS 2100 Euterpe Pl		24a. REC'D BY REGISTRAR JUN 6 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

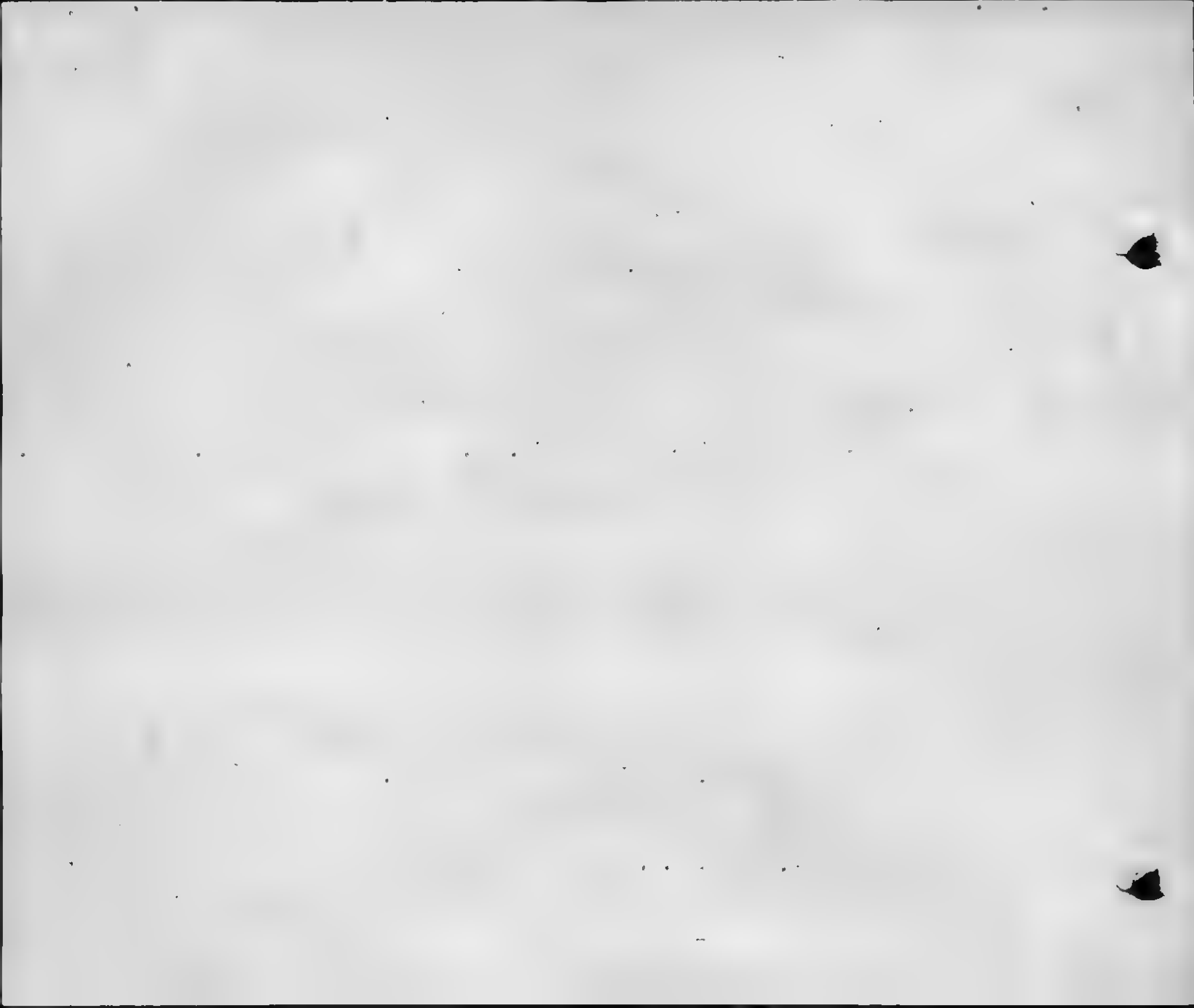
CERTIFICATE OF DEATH

6552

06536

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>143 Days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 X - 3</u> d. STREET ADDRESS <u>1423 Eighth Street</u>	
3. NAME OF DECEASED (Type or print) <u>KEVICK H. REEDER</u> First Middle Last		4. DATE OF DEATH <u>June 10, 19 61</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 8, 1921</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>File Clerk</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Reeder</u>		14. MOTHER'S MAIDEN NAME <u>Anna Washington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW-11</u>		16. SOCIAL SECURITY NO. <u>578-12-2227</u>	
17. INFORMANT <u>Clin. Rec. VAH, Baltimore 18, Md.-Ft Howard Div.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA OF ESOPHAGUS</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Cachexia</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 18, 1961</u> to <u>June 10, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 10, 1961</u> , and that death occurred at <u>8:30 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph J. Cillo M.D.</u>		22b. DATE SIGNED <u>6-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph J. Cillo, M.D.</u>		22d. ADDRESS <u>VAH, Baltimore 18 Md - Ft Howard Div.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-12-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Virginia</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S Phillips</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 14 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		25c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Virginia</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

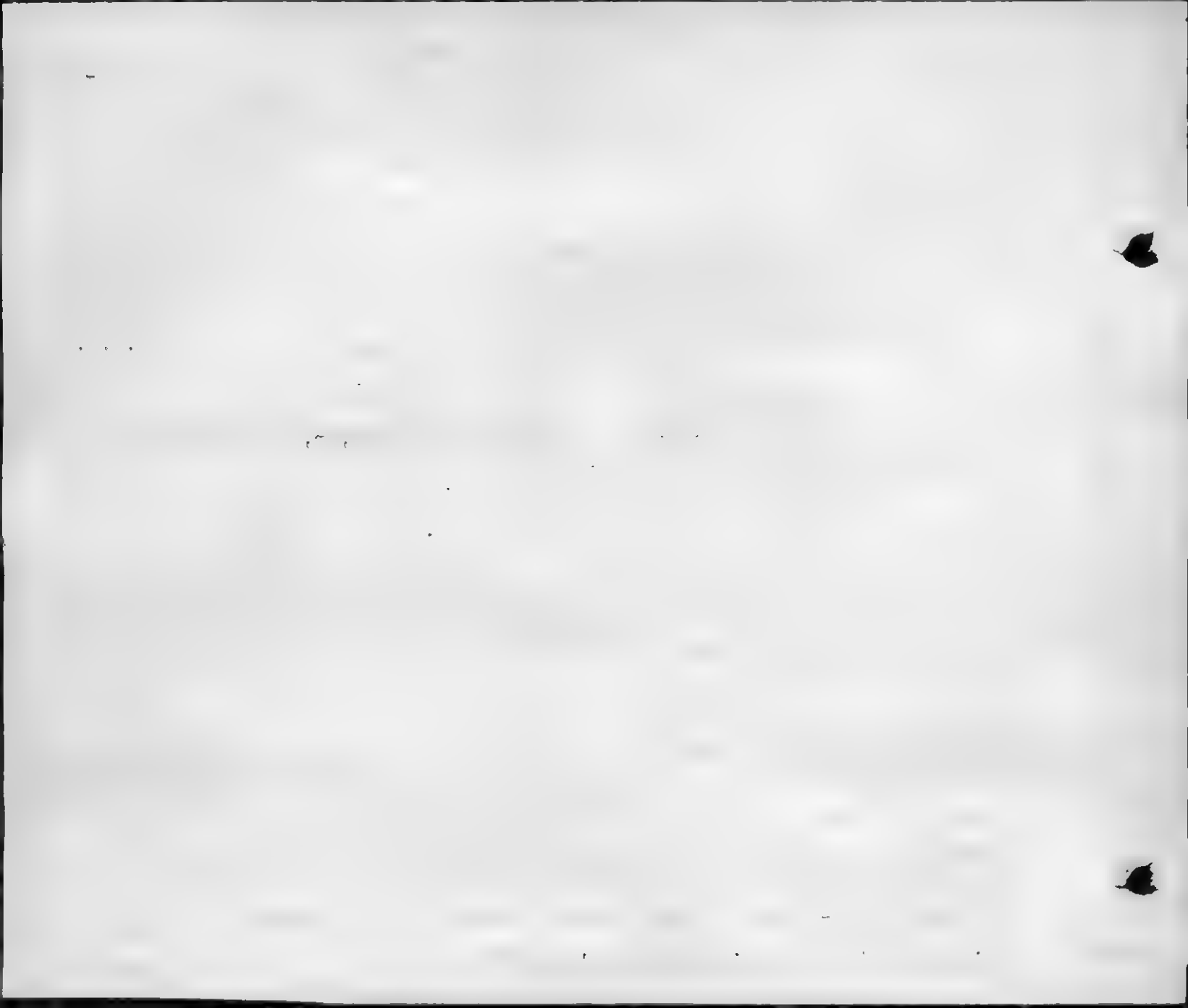
6553

CERTIFICATE OF DEATH

Reg. Dist. No. 06537

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2910 Greentop Road				d. STREET ADDRESS 2910 Greentop Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Myrtle Middle Elizabeth Last Reese				4. DATE OF DEATH Month JUNE Day 16 Year 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1901		9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Grant McKaig				14. MOTHER'S MAIDEN NAME Ida May McKaig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Henry David Reese, Jr. Address Cockeysville 2910 Greentop Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CEREBROVASCULAR DISEASE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 HRS 5 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 12, 1961 , to JUNE 16, 1961 , that I last saw the deceased alive on JUNE 12, 1961 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2060 YORK RD DATE SIGNED 6/19/61							
ACTUAL SIGNATURE William A. Pillsbury M.D.				DATE SIGNED 6/19/61			
PHYSICIAN'S NAME (Type) William A. Pillsbury				TIMONIUM Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-19-61		22c. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore				24a. REC'D BY REGISTRAR DATE JUN 20 '61		24b. REGISTRAR'S SIGNATURE William S. Thane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

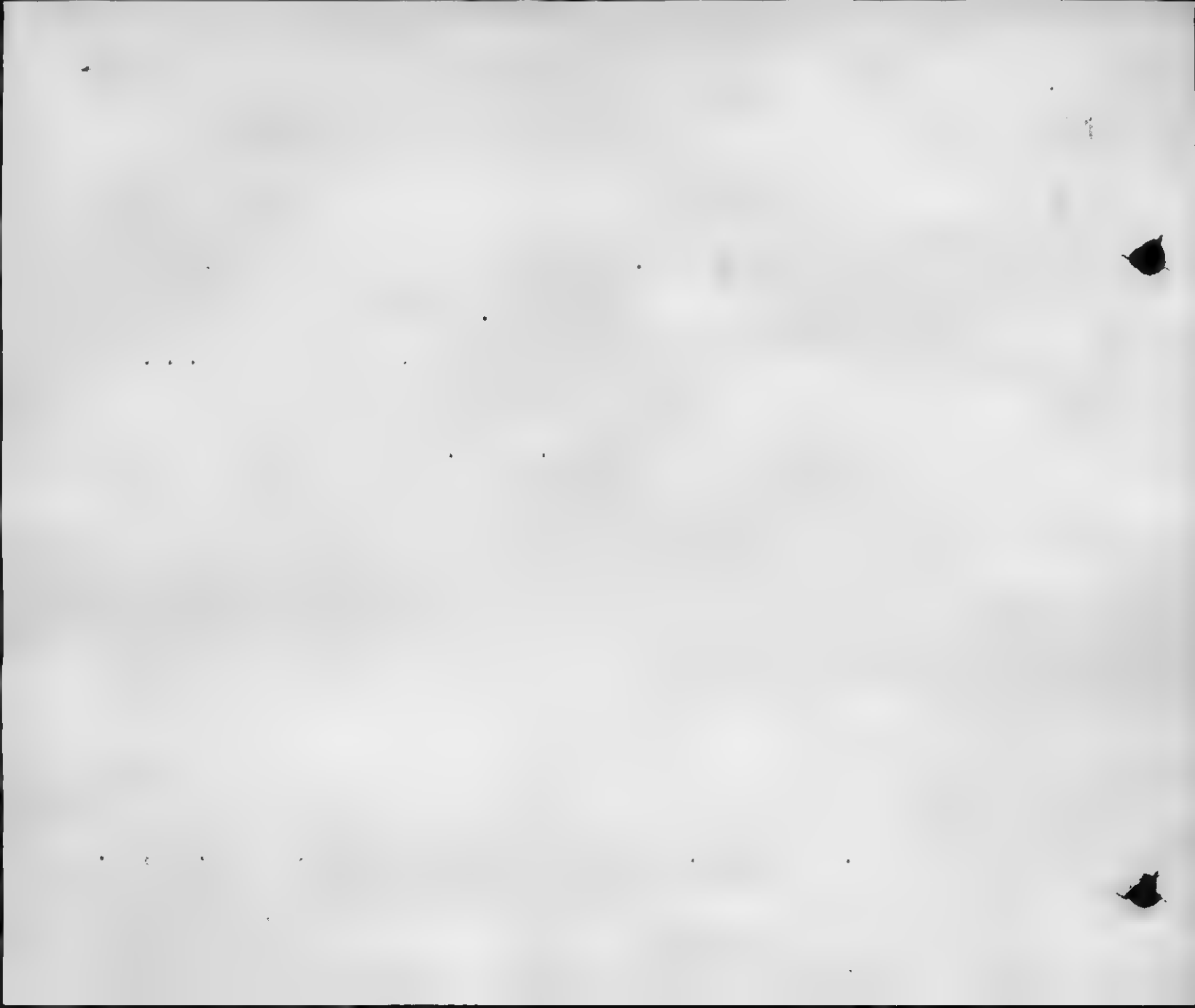


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
0554 Items 13 & 14 Film 6207 20/61 06538									
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
a. COUNTY		b. STATE				c. COUNTY			
Baltimore		Maryland				Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Baltimore						Towson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
531 Stevenson Lane		1108 Sleepy Dell Court							
3. NAME OF (Type or print)		First		Middle		Last		DATE OF DEATH	
Stanley G. Remington								June 23, 1961	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White				Sept. 5th 1875		85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Chairman of Board		Remington Books		Baltimore, Md		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
unknown		unknown							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Mr. John T. Remington-1108 Sleepy Dell Court							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Crowning Atherosclerosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH							
22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from June 19, 1961 to June 23, 1961, that (I) (we) last saw the deceased alive on June 19, 1961, and that death occurred at 9:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE		22b. PHYSICIAN'S NAME (Type)		22c. ATTENDING PHYS. M.D.		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED	
Dr. Charles E. Carr, Jr.		6201 York Road, Balto. 12, Md.						6/23/61	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		6-26-61		New Cathedral Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE		25d. JUN 26 '61	
John J. Tuckman, Son		North Pennsylvania Ave		1500 17th Rd				C. J. Tuckman	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06539

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 mth 7dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 675 Washington Blvd.			
3. NAME OF DECEASED (Type or print) First Charles Middle Newman Last Richards				4. DATE OF DEATH Month June Day 12 Year 19 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1890		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 12 Days 12 Hours 19 Min 61	IF UNDER 24 HRS Hours 19 Min 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) florist supplies		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Richards				14. MOTHER'S MAIDEN NAME Mary Wille			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensatory heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized and severe						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5 19 61 to June 12 19 61 , that (I) (we) last saw the deceased alive on June 12 19 61 , and that death occurred at 2:55 A. M. from the causes and on the date stated above							
22a. SIGNATURE Loretta Hsu		M. D. 6-12-61		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Loretta Hsu, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/14/61		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR JUN 14 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

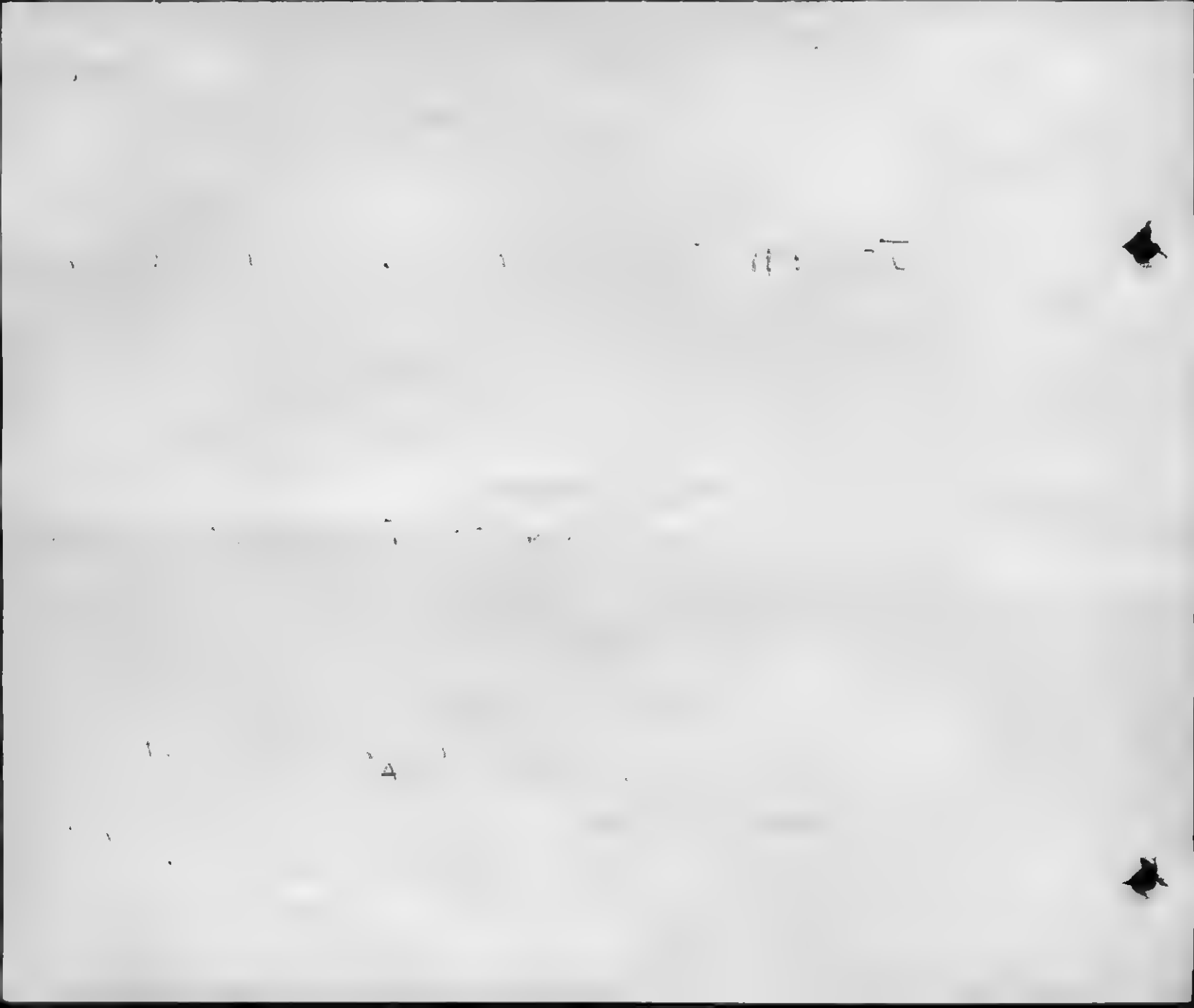
06540

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town <u>Rural - Rosedale</u> c. LENGTH OF STAY IN 1b <u>22 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8037 Old Philadelphia Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> d. STREET ADDRESS <u>8037 Old Philadelphia Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph John Ritko Sr.</u>		4. DATE OF DEATH <u>JUNE 13 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1911</u>
9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u> </u>
13. FATHER'S NAME <u>John Ritko</u>		14. MOTHER'S MAIDEN NAME <u>Anna Susko</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-073605</u>	
17. INFORMANT <u>Mary Ritko</u>		Address <u>8037 Old Philadelphia Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>17 yrs</u> DUE TO (b) <u>CARCINOMA OF Testicle</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1960</u> to <u>June 13, 1961</u> that (I) (we) last saw the deceased alive on <u>June 12, 1961</u> , and the death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Baumgardner</u> M.D.		22b. DATE SIGNED <u>6/13/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Balto 6 Md.</u>		22d. ADDRESS <u>Balto 6 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>June 16/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Czech</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>1211 Chesapeake Ave</u>		DATE <u>JUN 16 '61</u>	

MEDICAL CERTIFICATION

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06541

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN TB <u>76 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>121 Berlin Ave</u>			
3. NAME OF DECEASED (Type or print) <u>HERMAN R ROSE</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 3, 1907</u> 9. AGE (In years last birthday) <u>53</u> yrs. 10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>19</u> Hours <u>61</u> Min.				11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co. Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Rose</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>WW II 216-05-5547</u> 17. INFORMANT <u>Sarah Cook</u> Address _____				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PURULENT CHOLANGITIS WITH ABSCESSSES OF THE LIVER</u> (b) <u>ADENOCARCINOMA CECUM WITH METASTASES TO LYMPH</u> (c) <u>NONES AND LIVER BRONCHOPNEUMONIA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u> <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____				20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____				21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 17, 1961</u> to <u>June 1, 1961</u> , that <u>no</u> (we) last saw the deceased alive on <u>June 1, 1961</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>6/2/61</u> 22c. PHYSICIAN'S NAME (Type) <u>WALTER J. PIJANOWSKI, M.D.</u> 22d. ADDRESS <u>VAH BALTO 18, MD FT HOWARD DIV.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>6/6/1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> 25a. REC'D BY REGISTRAR <u>[Signature]</u> <u>Katie R. Williams</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>322 N Schroeder St Balto Md</u> DATE <u>JUN 5 '61</u>							

MEDICAL CERTIFICATION

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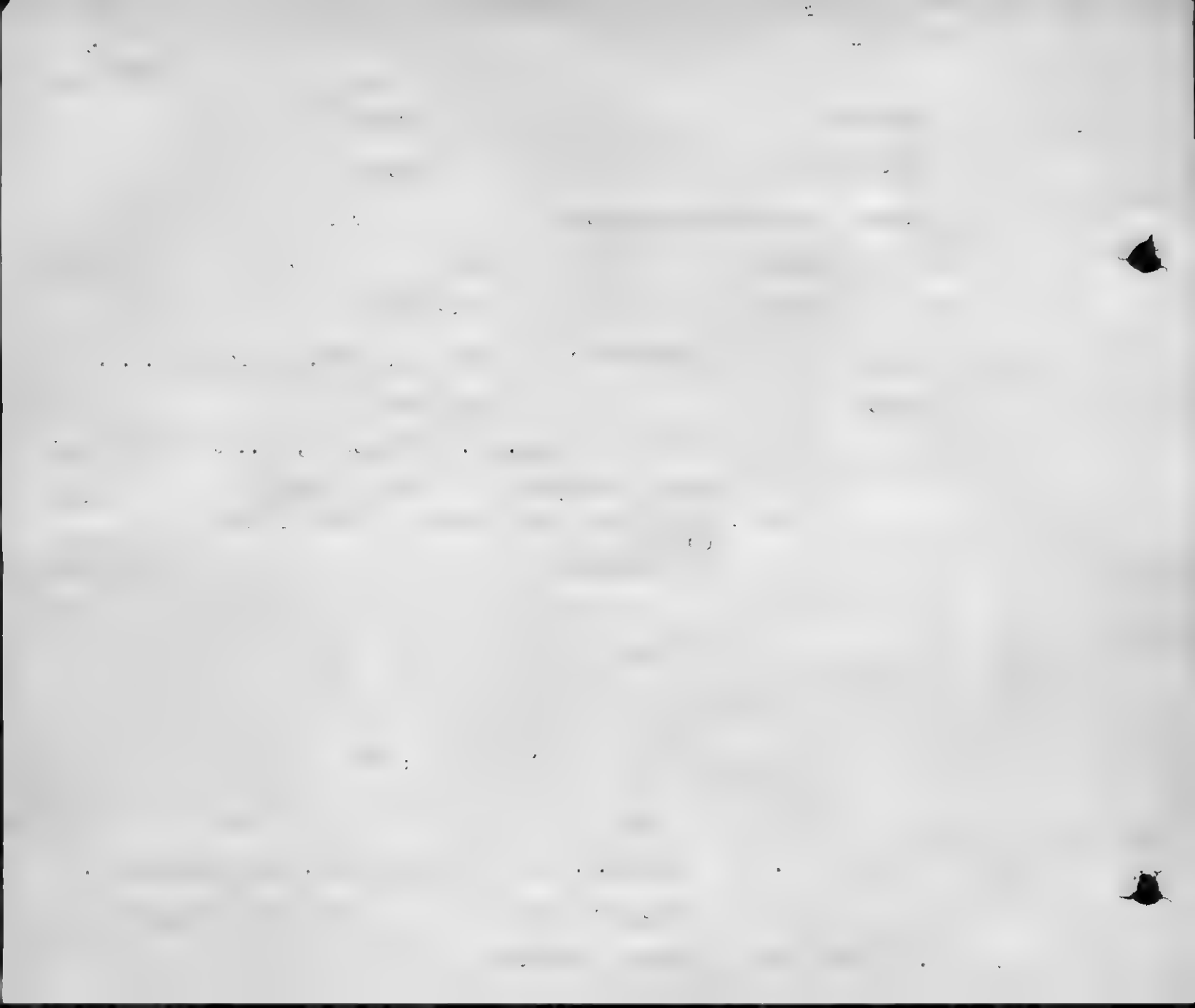
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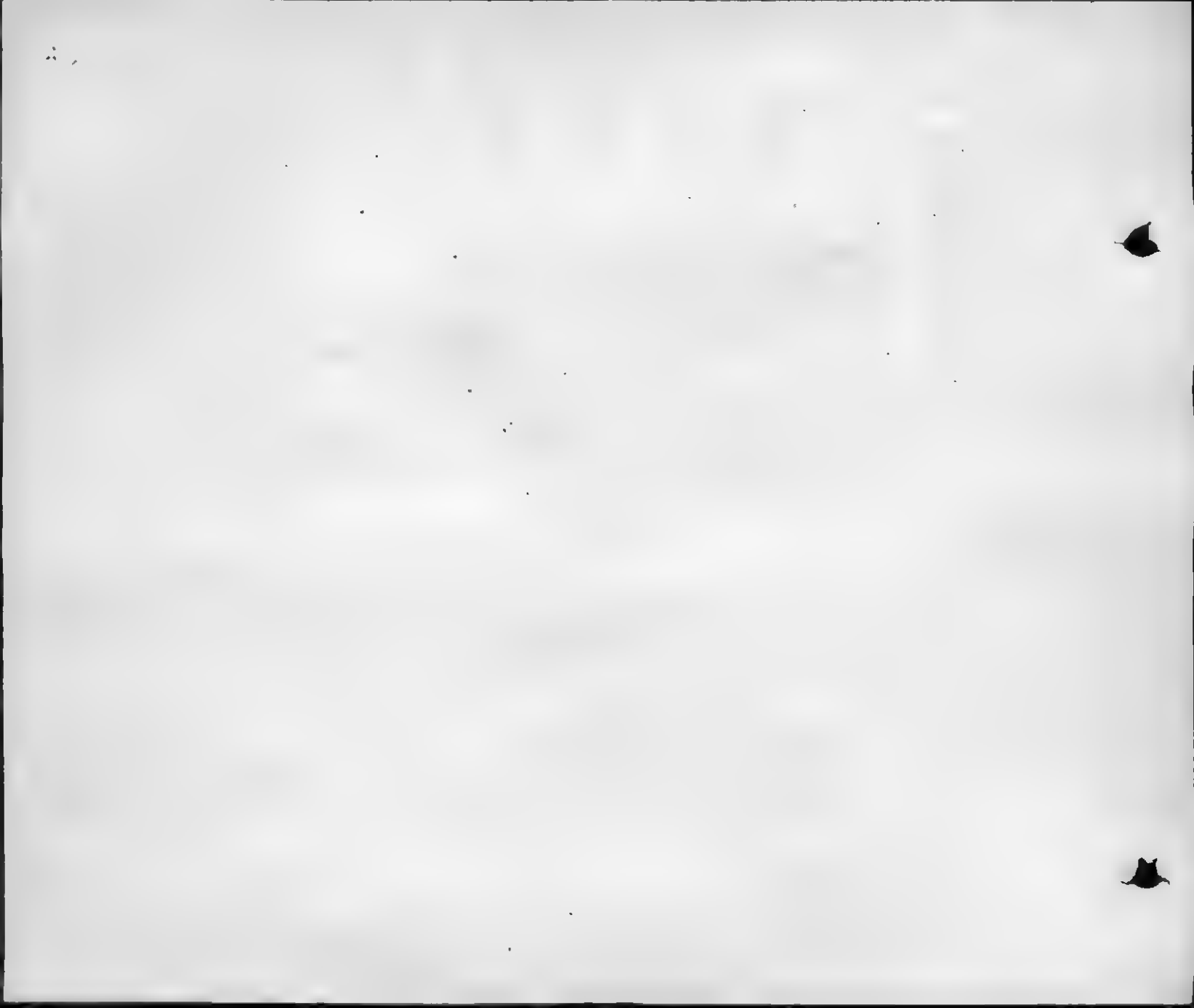
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06542

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY _____	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c LENGTH OF STAY IN 1b _____	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Times</u>		e STREET ADDRESS <u>2925 Rockrose Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>E</u> Middle <u>Roseman</u> Last		4. DATE OF DEATH Month <u>6</u> - Day <u>29</u> - Year <u>1961</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16-1890</u>
9 AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Caron?</u>		14. MOTHER'S MAIDEN NAME <u>Esther?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Belle Roseman - Same</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>June 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1961</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel J. Belloc</u>		22b. DATE SIGNED <u>6/30/61</u>	
22c. PHYSICIAN'S NAME (Type) _____		22d. ADDRESS <u>2320 Eutan Place</u>	
23a. BURIAL, CREMATON, REMOVA. (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-30-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Herring Run</u>	23d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Run</u> ADDRESS <u>2100 Eutan Place</u>		25a REC'D BY REGISTRAR DATE <u>JUL 5 '61</u>	
		25b REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06543**

6552

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point, Md. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Dispensary				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Inverness (22) d. STREET ADDRESS 1955 Haselmere Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pietro Bruno SACILOTTI First Middle Last 4. DATE OF DEATH June 6th, 1961 Month Day Year				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 7th, 1910 9. AGE (In years last birthday) 50 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Steel 11. BIRTHPLACE (State or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis Sacilotto 14. MOTHER'S MAIDEN NAME Amelia Pittle				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 212-01-9182 17. INFORMANT Mrs. Jean C. Sacilotto same as #2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 18.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>. ACTUAL SIGNATURE JACK C COLLINS M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) JACK C COLLINS ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-6-61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			
22d. LOCATION (City, town, or county) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22 ADDRESS 24a. REC'D BY REGISTRAR DATE 6-12-61 24b. REGISTRAR'S SIGNATURE William J. Kirsch					

MEDICAL CERTIFICATION

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

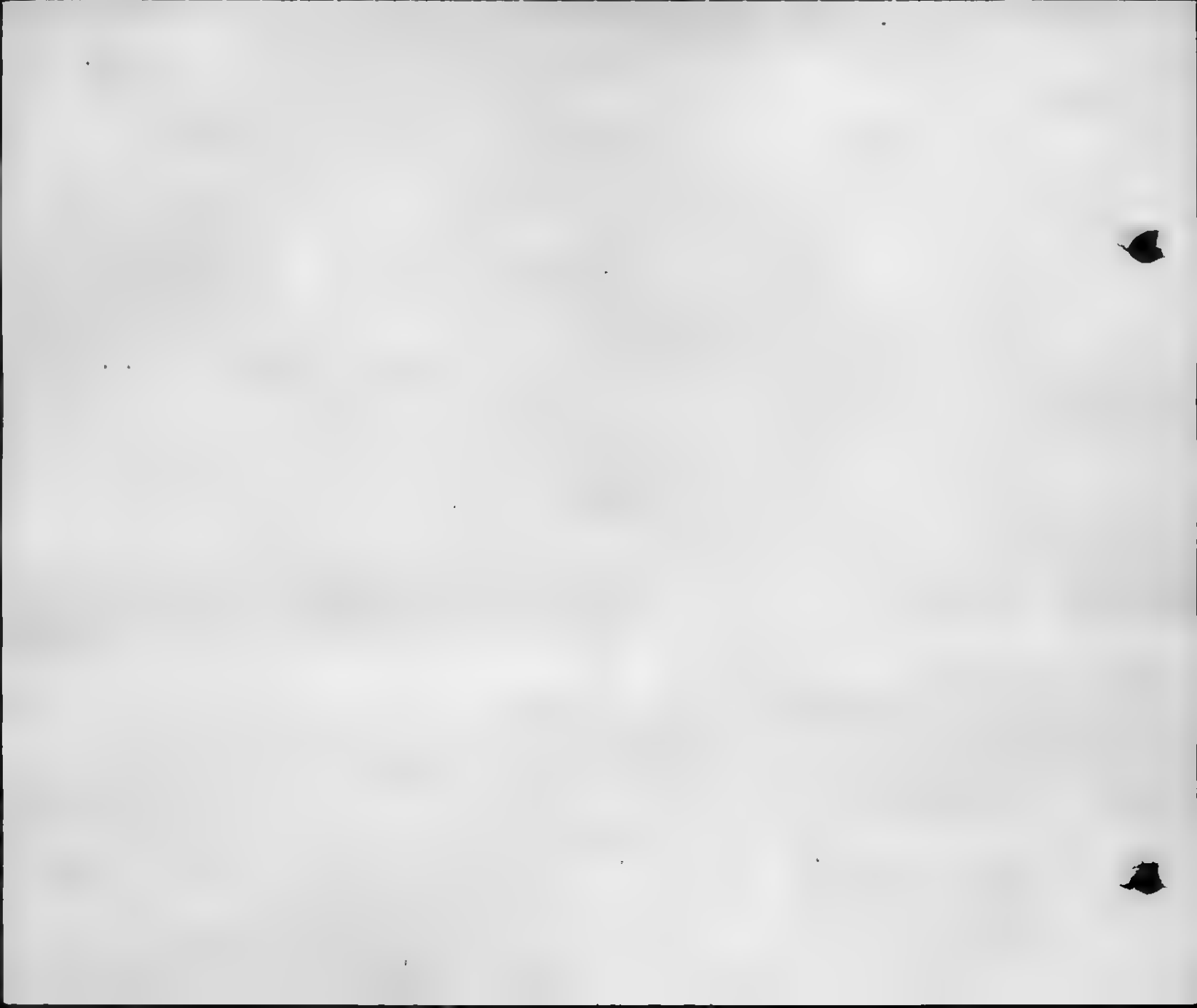
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06544

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATON S VILLE</u>				c. LENGTH OF STAY IN 1b <u>23 DAYS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE HOSPITAL</u>				d. STREET ADDRESS <u>4717 ALGATE GREEN</u>			
3. NAME OF DECEASED (Type or print) First <u>TLA</u> Middle <u>N.</u> Last <u>S ALLERWALD</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>15</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 24, 1877</u>	
9. AGE (in years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Un known</u>				14. MOTHER'S MAIDEN NAME <u>Un known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Records: Spring Grove Hospital</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <u>584X</u> DUE TO <u>Acute biliary obstruction</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Calculus in common Bile Duct</u>							
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Cardiovascular Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 23, 1961</u> to <u>June 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 15, 1961</u> , and that death occurred at <u>8:10</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jose R. Arizaga</u> M.D.				22b. DATE SIGNED <u>6-15-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Jose R. Arizaga M.D.</u>				22d. ADDRESS <u>Spring Grove Hospital</u> <u>Catonsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6-19-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
23d. LOCATION (City, town or county) <u>Balti - Md.</u>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. L. & Son - Catonsville - 28-Md.</u>				25a. REC'D BY REGISTRAR <u>DATE JUN 21 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0561

06545

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1620 Forest Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Middle Last 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF DEATH JUNE 29 1961 9. AGE (in years last birthday) 97 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foundry Worker 11. BIRTHPLACE (County & State, or foreign country) Md. United States 12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Mildred Beisinger Address 1620 Forest Park, Balto	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4-2-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 1961 to June 29 1961 , that (I) (we) last saw the deceased alive on June 29 1961 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D. 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22b. DATE SIGNED 6-29-61 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/1/1961	
23c. NAME OF CEMETERY OR CREMATORY London Park CEM BALTO.		23d. LOCATION (City, town or county) (State) Md.	
24 FUNERAL DIRECTOR'S SIGNATURE G. TRUMAN Schwab ADDRESS 3512 Fred. Ave.		25a. REC'D BY REGISTRAR JUL 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

within 24 hours after death. The law requires that the death certificate be executed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(29)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C562

Item 2 & 7 151m 0289 6/29/61 mh

06546

1. PLACE OF DEATH a. COUNTY Balto MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EATonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 30	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit NURS. Hm.		d. STREET ADDRESS 1613 Light St. 3V01-1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rose Middle SCIACCA Last —		4. DATE OF DEATH Month 6- Day 21 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH — 1870 90
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	11. IF UNDER 24 HRS. Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Family	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO — (c) DUE TO —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Vaginal Wall resected 8/2/60		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 Mar 1960 to 6/21/61 , that (I) met last saw the deceased alive on 6/20/61 and that death occurred on 8/25/61 from the causes and on the date stated above.			
22a. SIGNATURE W.E. McGrath MD.		22b. DATE SIGNED 6/21/61	
22c. PHYSICIAN'S NAME (Type) W.E. McGrath MD.		22d. ADDRESS 1303 Frederick Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 6-24-61	
23c. NAME OF CEMETERY OR CREMATORY New Calverton		23d. LOCATION (City, town, or county) (State) Balto	
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave		25a. REC'D BY REGISTRAR DATE IN 26 '61	
ADDRESS 130 E. Fort Ave		25b. REGISTRAR'S SIGNATURE Robert S. Perna	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

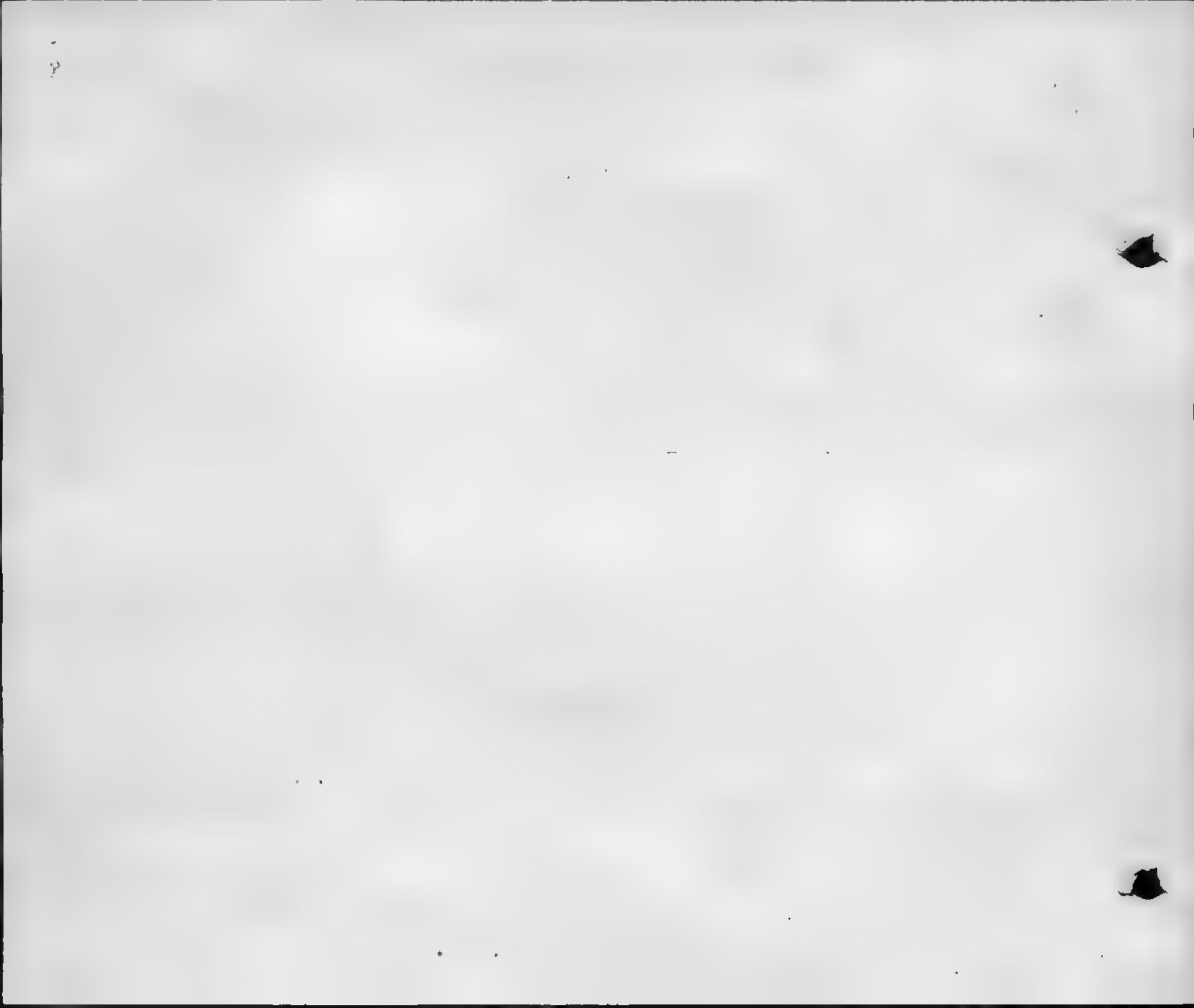
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6563

06547

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Lake Park</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Twila Ruth Shaffer</u>		4. DATE OF DEATH <u>9/30/1917</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>9/26/1873</u> 9. AGE (In years last birthday) <u>43</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Garrett County, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin Franklin Shaffer (deceased)</u> 14. MOTHER'S MAIDEN NAME <u>Eula Catherine Elsey (deceased)</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMATION <u>Rosewood Records, Owings Mills, Maryland</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bact and chronic bronchopneumonia</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>11X</u> DUE TO (c) <u>11X</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19...., to....., 19...., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at <u>10:00 AM</u> on the causes and on the date stated above.							
22a. SIGNATURE <u>Pete W Rieckert</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Pete W Rieckert</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>4307 Mainfield Ave Balto 14</u>		22b. DATE SIGNED <u>6-26-61</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial 7/1/61</u> REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u> ADDRESS <u>Oakland, Md</u>		23d. LOCATION (City, town or county) <u>Garrett County</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Leighton</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>JUL 3 '61</u>		25b. REGISTRAR'S SIGNATURE			



VS A15 (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth29dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 332 Montgomery Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna		Middle Frances		Last Shipe	
4. DATE OF DEATH Month June		Day 20		Year 19 61	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 27, 1902		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) restaurant owner		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Franklin Knisley		14. MOTHER'S MAIDEN NAME Deola Feltner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk own		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple metastases DUE TO Carcinoma of the thyroid CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE (c) 194X		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SPRING GROVE STATE HOSPITAL	
20f. (City or town) Laurel, Md.		(County) Prince George's		(State) Md.	
21. I certify that I attended the deceased from March 20, 1961 to June 20, 1961 , that I last saw the deceased alive on June 20, 1961 , and that death occurred at 10:35 PM , from the causes and on the date stated above.		p. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		DATE SIGNED 6-21-61	
ACTUAL SIGNATURE Stella Wachslar		M.D. Stella Wachslar, M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 24, 1961		22b. DATE THEREOF June 24, 1961		22c. NAME OF CEMETERY OR CREMATORY Laurel, Md.	
22d. LOCATION (City, town, or county) Laurel, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt L. Arnoldson		ADDRESS 313 Tallott St.		24a. REC'D BY REGISTRAR June 27 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hinkle					



1
FOR STATE
HEALTH DEPT.

THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, IT MAY BE EXTENDED TO 72 HOURS AFTER DEATH. THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CHIEF MEDICAL EXAMINER, WHO SHALL BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. FILE PAGES 1 AND 2 WITH THE STATE BOARD OF HEALTH. OR ITS DESIGNATED AGENT, PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

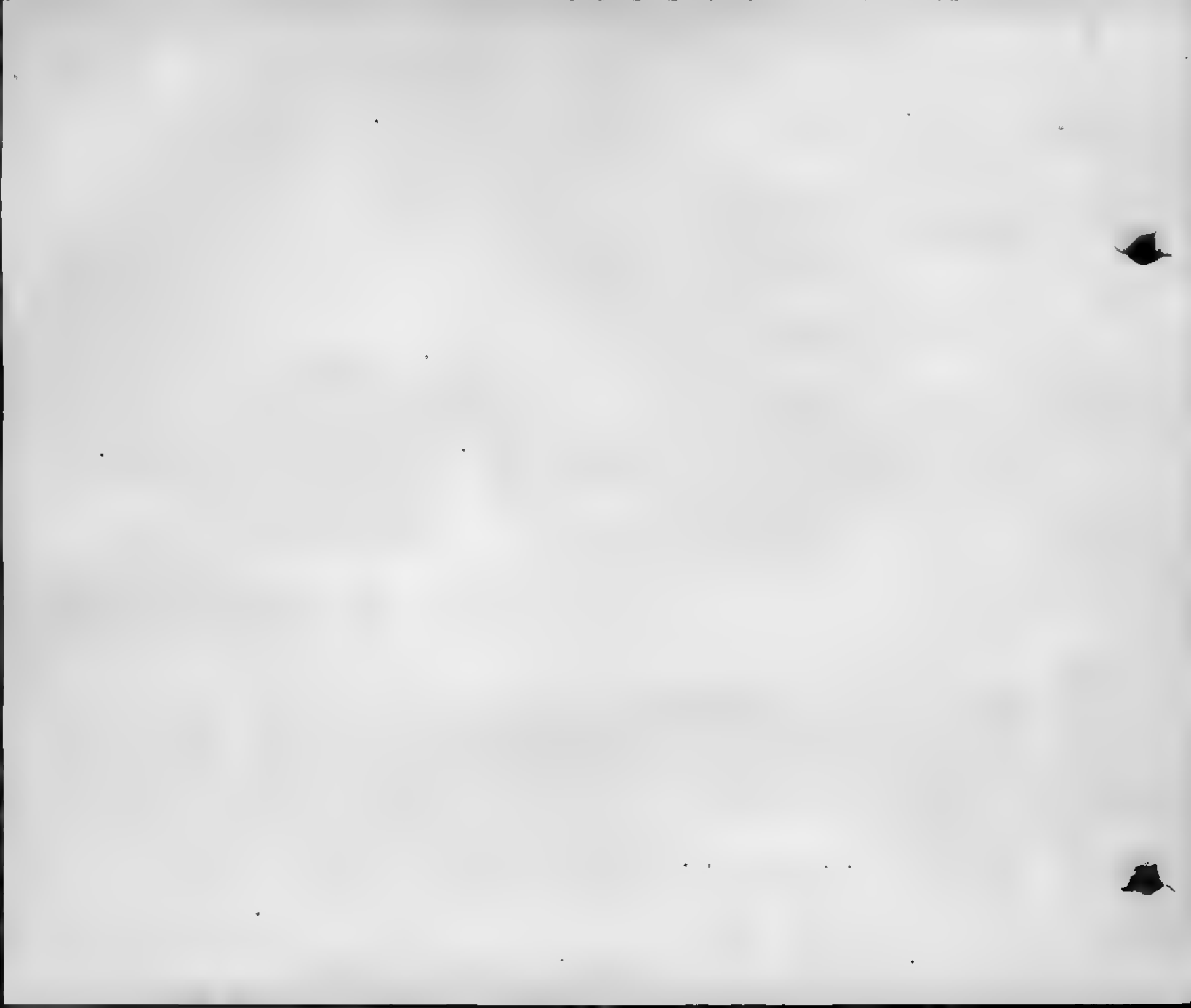
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6565

06549

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Lancaster</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u> d. STREET ADDRESS <u>624 Wheatland Drive</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indle River #20</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>62 Kingston Park</u>		d. STREET ADDRESS <u>624 Wheatland Drive</u>	
3. NAME OF DECEASED (Type or print) <u>JULIUS PRESTON SHUTZ</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u>	
11. IF UNDER 24 HRS.: Hours <u>7</u> Min. <u>15</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Shutz</u>		14. MOTHER'S MAIDEN NAME <u>Joanna Reeling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Julius P. Shutz Jr. Box 155 Pasadena, Ill.</u>	
17. INFORMANT <u>Julius P. Shutz Jr. Box 155 Pasadena, Ill.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis and Hypertension</u> (b) <u>Cardio-Vascular Disease</u> (c) <u>44? x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 15-61</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/25/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sleeper Funeral Home</u>		22d. LOCATION (City, town, or country) (State) <u>York, Penna.</u>	
23. FUNERAL DIRECTOR <u>James L. Rughwiler</u>		24a. REC'D BY REGISTRAR <u>JUN 26 '61</u>	
ADDRESS <u>1407 Eastern Ave. #21</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

MEDICAL CERTIFICATION

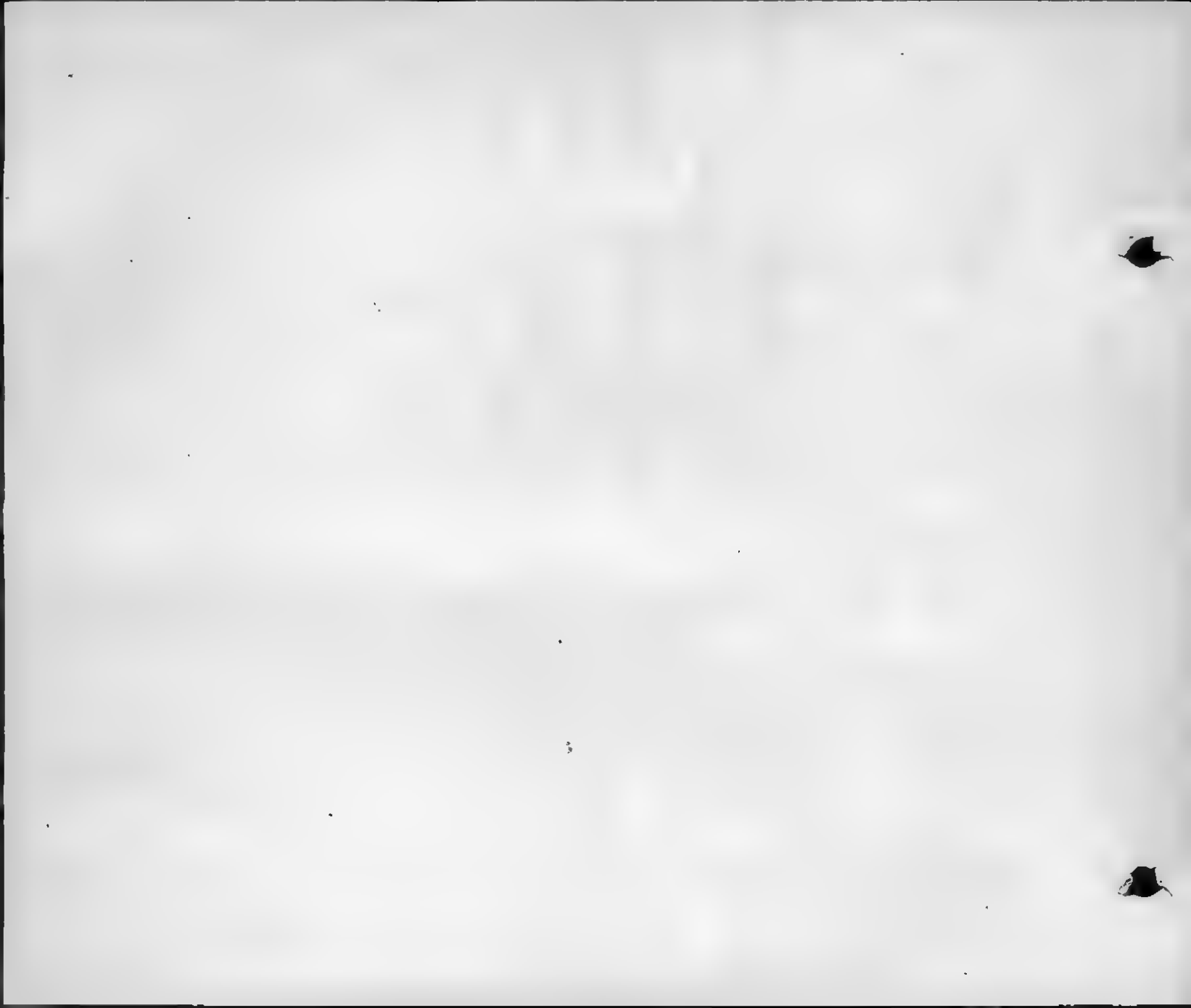


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06550

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>412 Highland Rd</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES C SKIRVAN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/1872</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patrolman</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Police Dept</u>	
13. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		14. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. FATHER'S NAME <u>Anthony Skirvan</u>		16. MOTHER'S MAIDEN NAME <u>Donna Skirvan</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <u>212-07-4703</u>	
19. INFORMANT <u>Joseph Skirvan</u>		20. ADDRESS <u>412 Highland Rd</u>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Chronic renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		26. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that I attended the deceased from <u>Oct 19, 1959</u> to <u>Jan 17, 1961</u> , that I last saw the deceased alive on <u>Jan 17, 1961</u> , and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick J. Vollmer</u> M.D.		ADDRESS (Street, city or town, state) <u>6100 York Rd Baltimore Md</u> DATE SIGNED <u>Jan 17, 1961</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>		<u>BALTO - 12 MD</u>	
30. BURIAL, CREMATION, REMOVAL (Specify)		31. DATE THEREOF <u>6/20/61</u>	
32. NAME OF CEMETERY OR CREMATORY <u>Greenland</u>		33. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
34. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley</u> ADDRESS <u>1318 Light</u>		35. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 21 '61</u>	
36. REGISTRAR'S SIGNATURE <u> </u>		37. REGISTRAR'S SIGNATURE <u> </u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

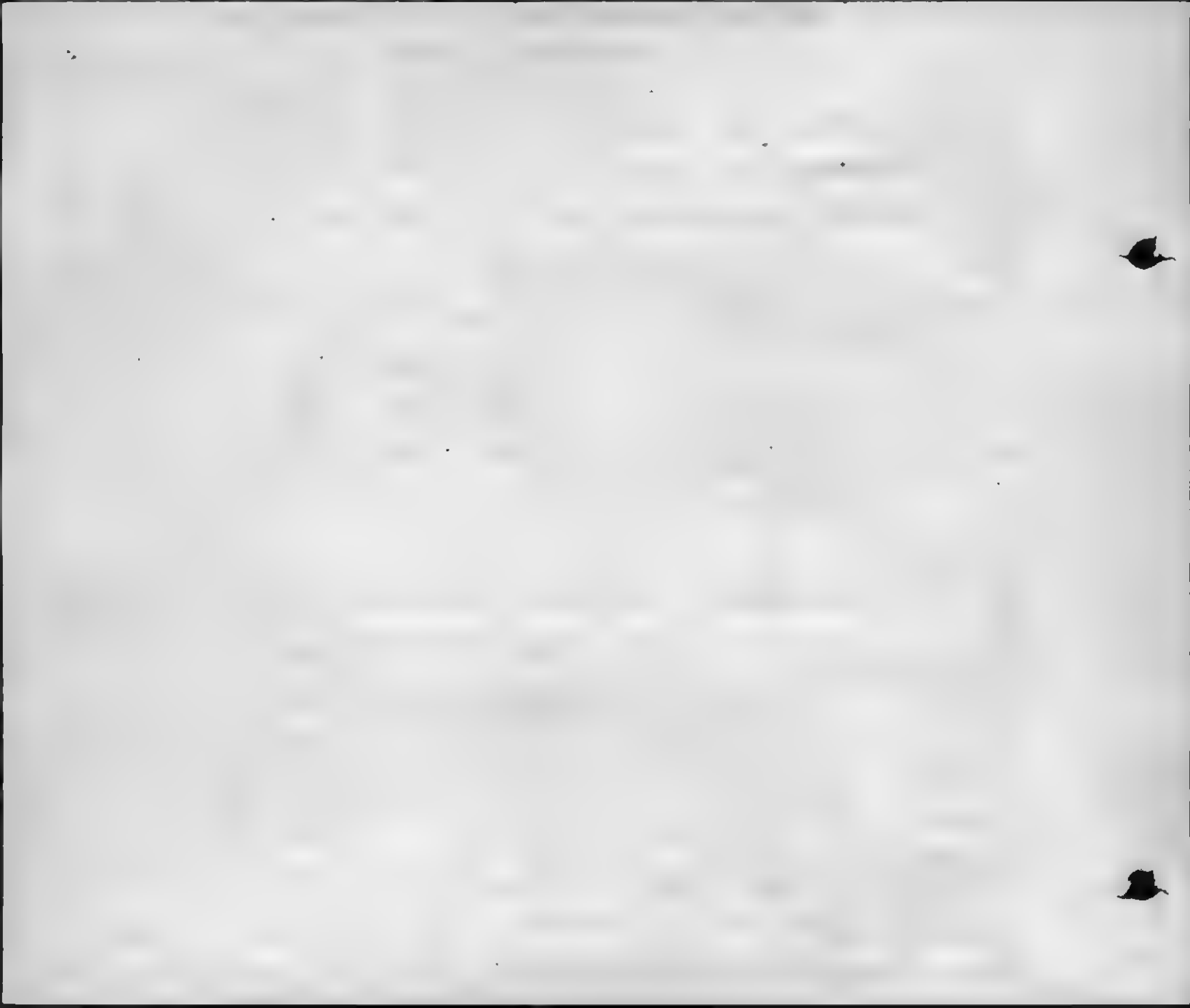
CERTIFICATE OF DEATH

Reg. Dist. No. **06551**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5315 Lombard Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hood Nursing Home		d. STREET ADDRESS 5628 Carville Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle A. Last SLATER		4. DATE OF DEATH Month June Day 15 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19-1887
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Miles Fleeger		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT George H. Slater		Address 5628 Carville Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Failure DUE TO (b) Arteriosclerotic Condition DUE TO (c) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28 , 19 61 , to 6/15 , 19 61 , that I last saw the deceased alive on 6/15 , 19 61 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1311 Francis Ave. Baltimore, Md. DATE SIGNED Arthur J. Hume			
ACTUAL SIGNATURE J. N. Frederick		M.D. 1311 Francis Ave. Baltimore, Md.	
PHYSICIAN'S NAME (Type) J. N. Frederick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 19/61	22c. NAME OF CEMETERY OR CREMATORY Louisa Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William J. Henry		ADDRESS 5646 Carville Ave.	
24a. REC'D BY REGISTRAR DATE JUN 20 '61		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	

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0567



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06552

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines N.H.		e. STREET ADDRESS 419 South Bouldin St.	
3. NAME OF DECEASED (Type or print) Conrad First Middle Last Smit		4. DATE OF DEATH Month 6 Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Otis Smit		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Marie Bierau, 419 S. Bouldin St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Decompression DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 wks. 1237.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-12-1961 , to 6-23-1961 , that I last saw the deceased alive on 6-22-1961 , and that death occurred at 5:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave Baltimore-28 Md. DATE SIGNED 6-24-61			
ACTUAL SIGNATURE Wilmer K. Ballager		M.D. 6209 Frederick Ave Baltimore-28 Md.	
PHYSICIAN'S NAME (Type) Wilmer K. Ballager		M.D. Baltimore-28 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 26, 1961	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Baltimore County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Homes, Baltimore, Md.		ADDRESS	
24a. REC'D BY REGISTRAR JUN 27 61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



FOR STATE
HEALTH DEPT

(M)

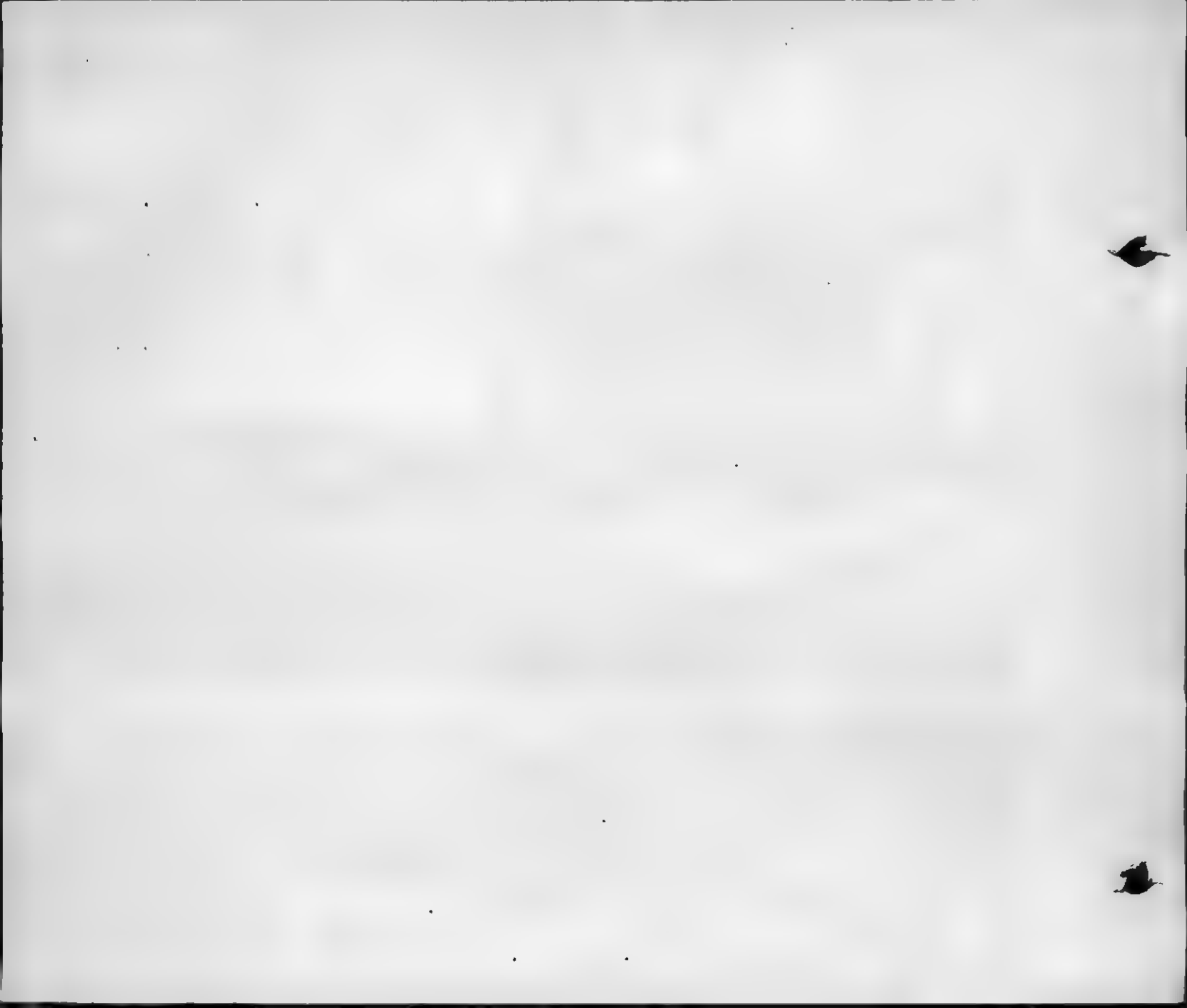
6563

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06553

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 16 <u>? Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Live Moss Detention Beach, Bear Creek</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>8010 Kavanaugh Rd. 22, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>Ann</u> Last <u>Sollars</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grange Elementary</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Walter Sollars</u>		14. MOTHER'S MAIDEN NAME <u>Uvee Tyler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mr. Walter Sollars</u>		Address <u>8010 Kavanaugh Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning - Accidental</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>She and playmate were floating on their backs</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6/14</u> 1961 p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bear Creek</u>	20f. (City or town) <u>Dundalk</u> (County) <u>Balto</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack Collins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack Collins, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>June 18, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Elk Garden, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. DUDA</u>		ADDRESS <u>7922 Wise Ave. 22, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 19 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

06554

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shepperd Rd.		e. STREET ADDRESS Shepperd Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Charlotte Payne Sparks		4. DATE OF DEATH Month Day Year 6-21-61 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr. Thomas Payne		14. MOTHER'S MAIDEN NAME Emma Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Dorothy S. Hutchins,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20, 1961 to June 21, 1961 that I last saw the deceased alive on June 20, 1961 and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) PARKTON, Md. DATE SIGNED 6/22/61			
ACTUAL SIGNATURE A. M. France M.D.		PHYSICIAN'S NAME (Type) A. M. FRANCE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-23-61	22c. NAME OF CEMETERY OR CREMATORY St. James	22d. LOCATION (City, town, or county) (State) Monkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson4, Md.		ADDRESS 4, Md.	
24a. REC'D BY REGISTRAR DATE JUN 26 '61		24b. REGISTRAR'S SIGNATURE Charles L. France	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6571

CERTIFICATE OF DEATH

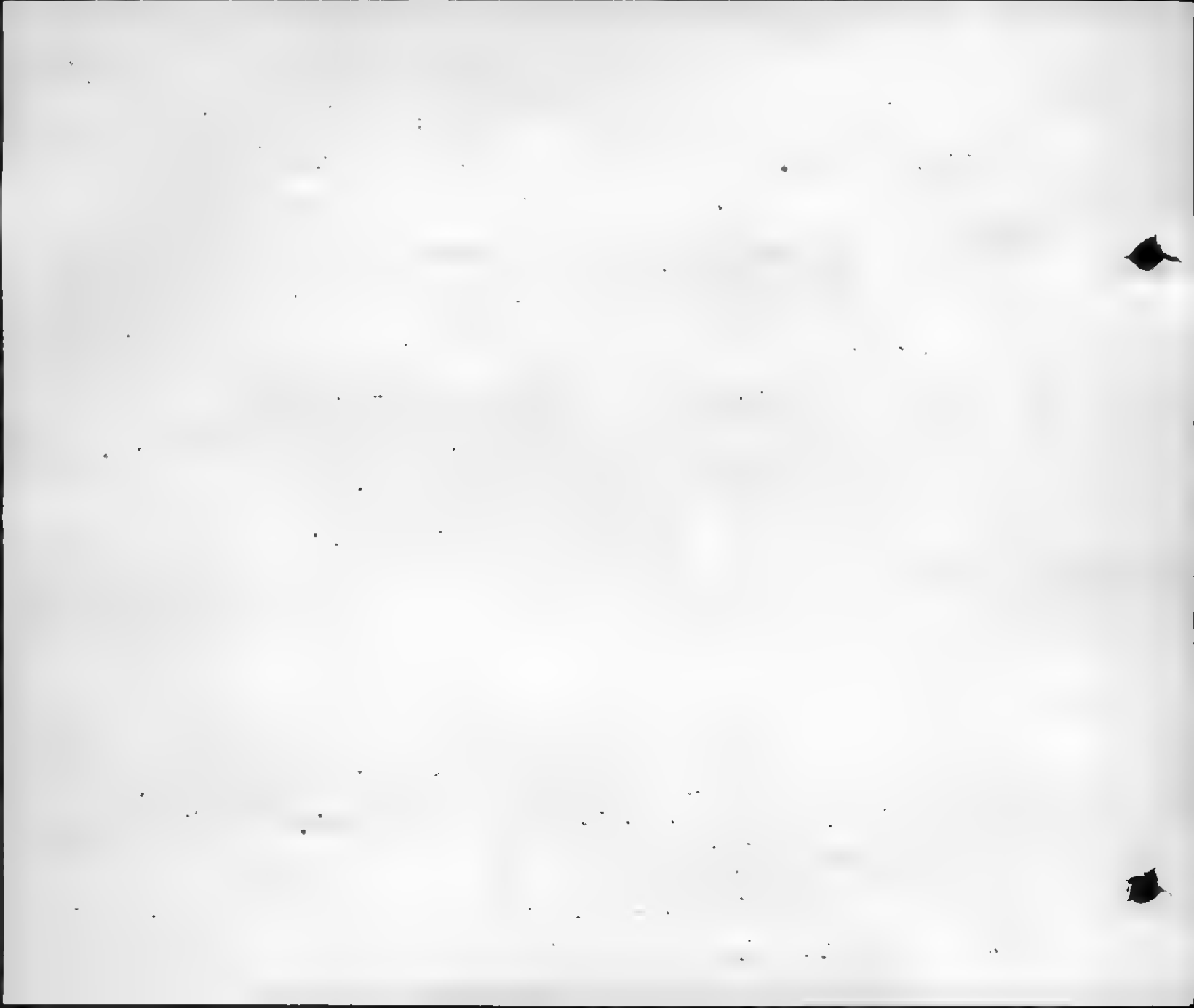
Reg. Dist. No 06555

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN c. LENGTH OF STAY IN b. 3 YRS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN d. STREET ADDRESS 3830 BROWN HILL RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAULINE First Middle Last 4. DATE OF DEATH JUNE 25 1961 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH FEB 3, 1921 9. AGE (In years last birthday) 40 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK H. ABRAMS 14. MOTHER'S MAIDEN NAME LAURETTA BELOTE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO INFORMANT Address VAUGHN SPARROW 3830 BROWN HILL RD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA THYROID 194X DUE TO C METAS. TO LIVER, SPINE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 12, 1960 , to JUNE 25, 1961 , that I last saw the deceased alive on JUNE 25, 1961 , and that death occurred at 4:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Randallstown Md DATE SIGNED 6/24/61 ACTUAL SIGNATURE Thomas E. Wheeler M.D. PHYSICIAN'S NAME (Type) THOMAS E. WHEELER			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 22b. DATE THEREOF 6-25-61 22c. NAME OF CEMETERY OR CREMATORY Bel-Haven Cemetery 22d. LOCATION (City, town, or county) (State) Accomac Co. VA.		23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc. 1217 ST Paul St. ADDRESS DATE JUN 28 '61 24a. REC'D BY REGISTRAR DATE JUN 28 '61 24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6572

06556

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton			c. LENGTH OF STAY IN 1b Life			X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8511 Belair Road				d. STREET ADDRESS 1 8511 Belair Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Last Steg				4. DATE OF DEATH Month 6 Day 8 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-19-1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Balto. Co.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George Hagley				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Leonard F. Steg 911^a Belair Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of head of pancreas 157X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to June 8, 1961 , that (I) (we) last saw the deceased alive on 6/5 1961 and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE H. A. Grott				22b. DATE SIGNED 6/9/61			
22c. PHYSICIAN'S NAME (Type) H. A. GROTT, MD				22d. ADDRESS 8100 Harford Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-12-1961		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION, city, town, or county (State) Parkville Md	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Road		25a. REC'D BY REGISTRAR DATE JUN 12 '61	
				25b. REGISTRAR'S SIGNATURE William S. Kraus			

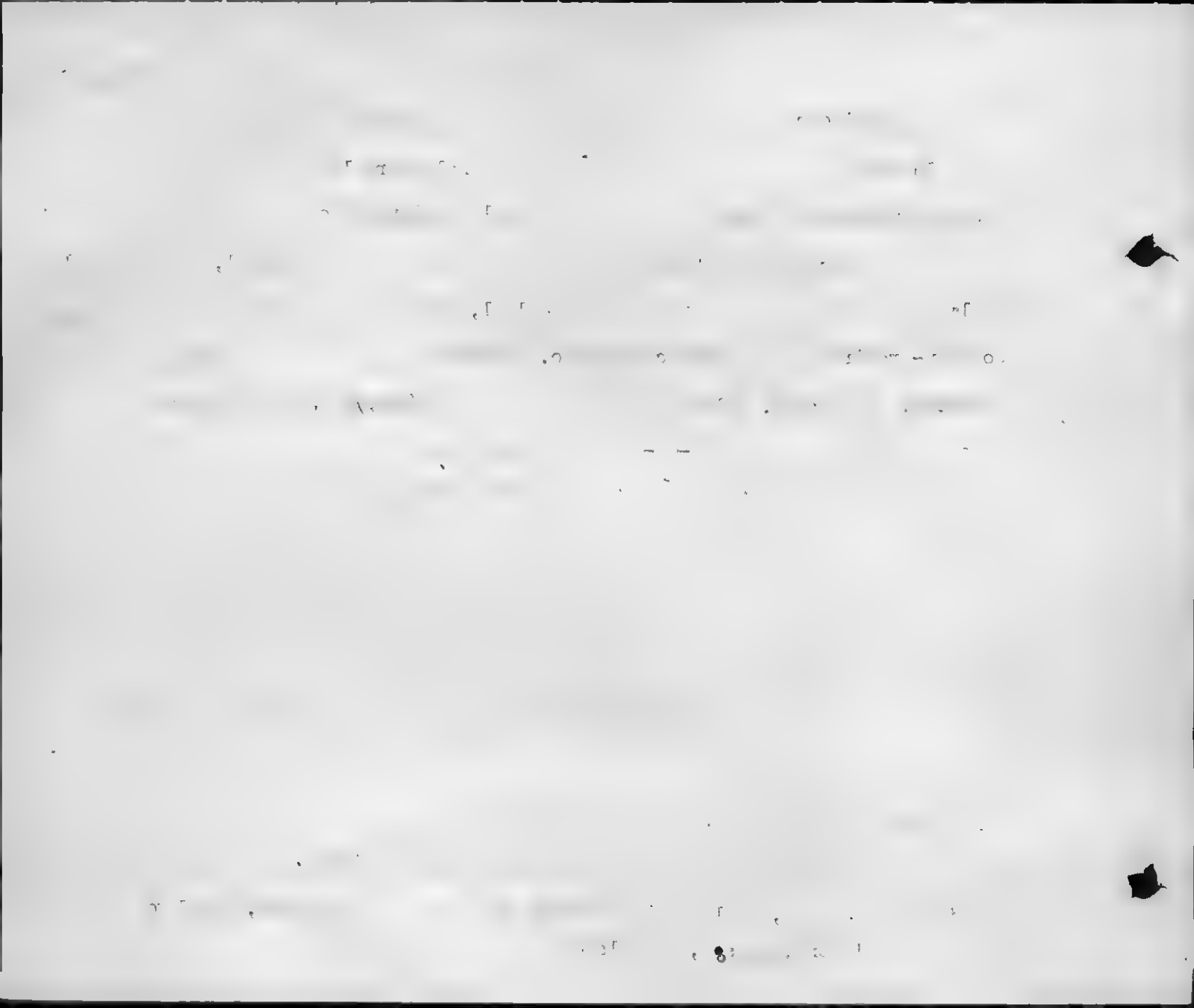


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6573
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6/12/61
Item 8 Film 3200
6/12/61
06557

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Codd Convalescent Home		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY 7 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 6512 Maplewood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN EDWARD SULLENS First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH July 1, 1878 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M'n.		4. DATE OF DEATH June 1, 1961 Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman- retired 10b. KIND OF BUSINESS OR INDUSTRY American Can Co. 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Sullens 14. MOTHER'S MAIDEN NAME Johanne Hubbard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-09-5093 17. INFORMANT Family Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension Cardio Vascular Disease Arteriosclerosis 44-2X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1950 to June 1, 1961 , that (I) (we) last saw the deceased alive on June 1, 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post 22c. PHYSICIAN'S NAME (Type) LAURENCE C. Post		22b. DATE SIGNED 6-5-61 22d. ADDRESS 6805-York Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF June 6, 1961 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland		25a. REC'D BY REGISTRAR JUN 8 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland ADDRESS			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6574

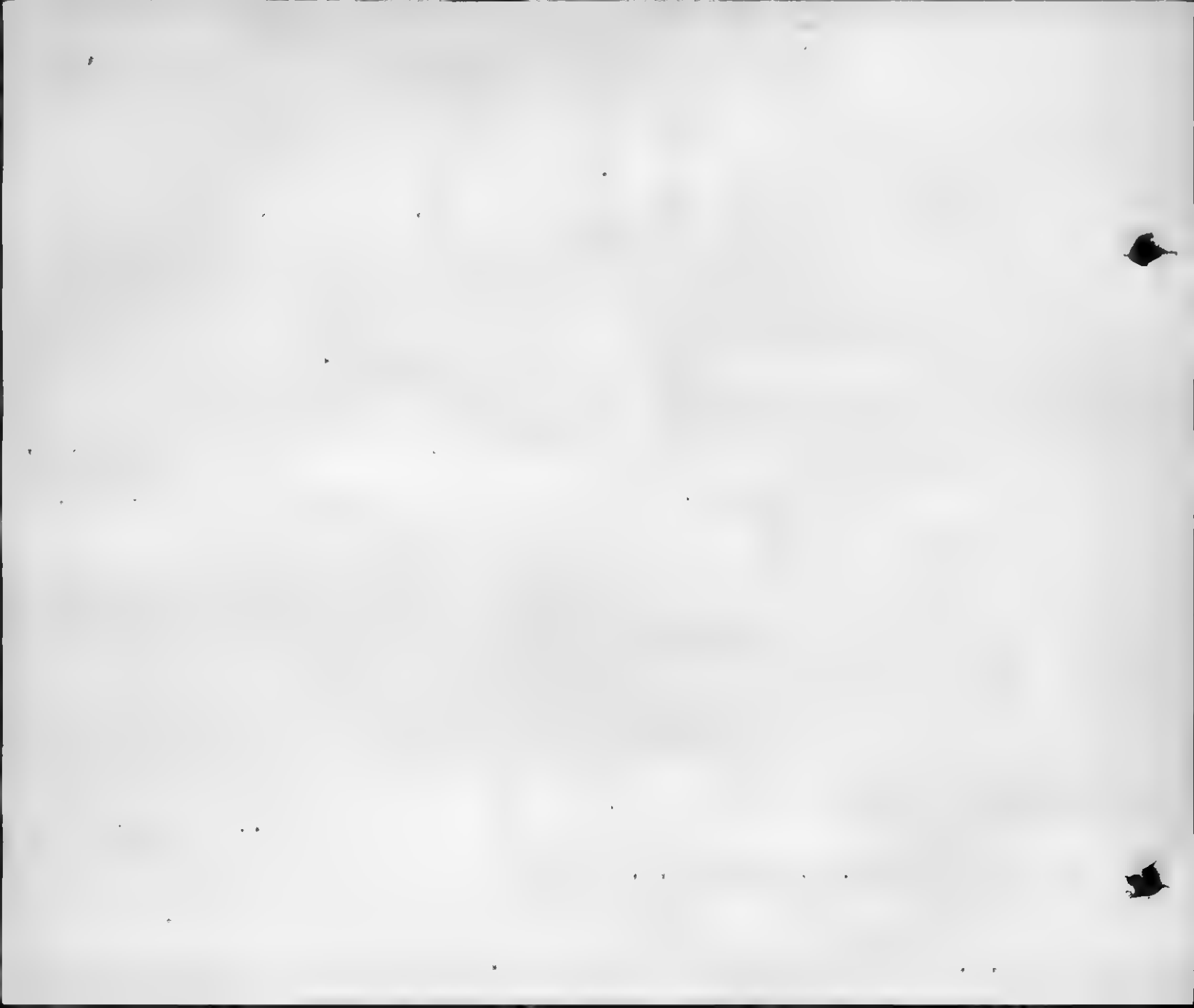
CERTIFICATE OF DEATH

Reg. Dist. No. **06558**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b 1 YR.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIDGEWAY MANOR	
e. STREET ADDRESS 910 Mt. Holly St.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle T. Last SULLIVAN		4. DATE OF DEATH Month JUNE Day 9 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1873
9. AGE (In years last birthday) 88 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME MICHAEL SHEEHAN		14. MOTHER'S MAIDEN NAME CATHERINE NILAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NORBERT J. SULLIVAN ELLICOTT CITY, Md.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		10 yrs.	
422.1 DUE TO (b) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Carcinoma right breast			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to 6/9 , 1961 , that I last saw the deceased alive on 6/8 , 1961 , and that death occurred at 1:30P M, from the causes and on the date stated above			
ACTUAL SIGNATURE Thos. E. Roach		ADDRESS (Street, city or town, state) 3629 Edmondson Ave., Balto-29-Md	
PHYSICIAN'S NAME (Type) Thos. E. Roach, M.D.		DATE SIGNED 6/10/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/12/61	22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL	22d. LOCATION (City, town, or county) (State) BALTIMORE, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H.W. MEARS & SON		ADDRESS 805 N. CALVERT ST.	
24a. REC'D BY REGISTRAR JUN 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krasa	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

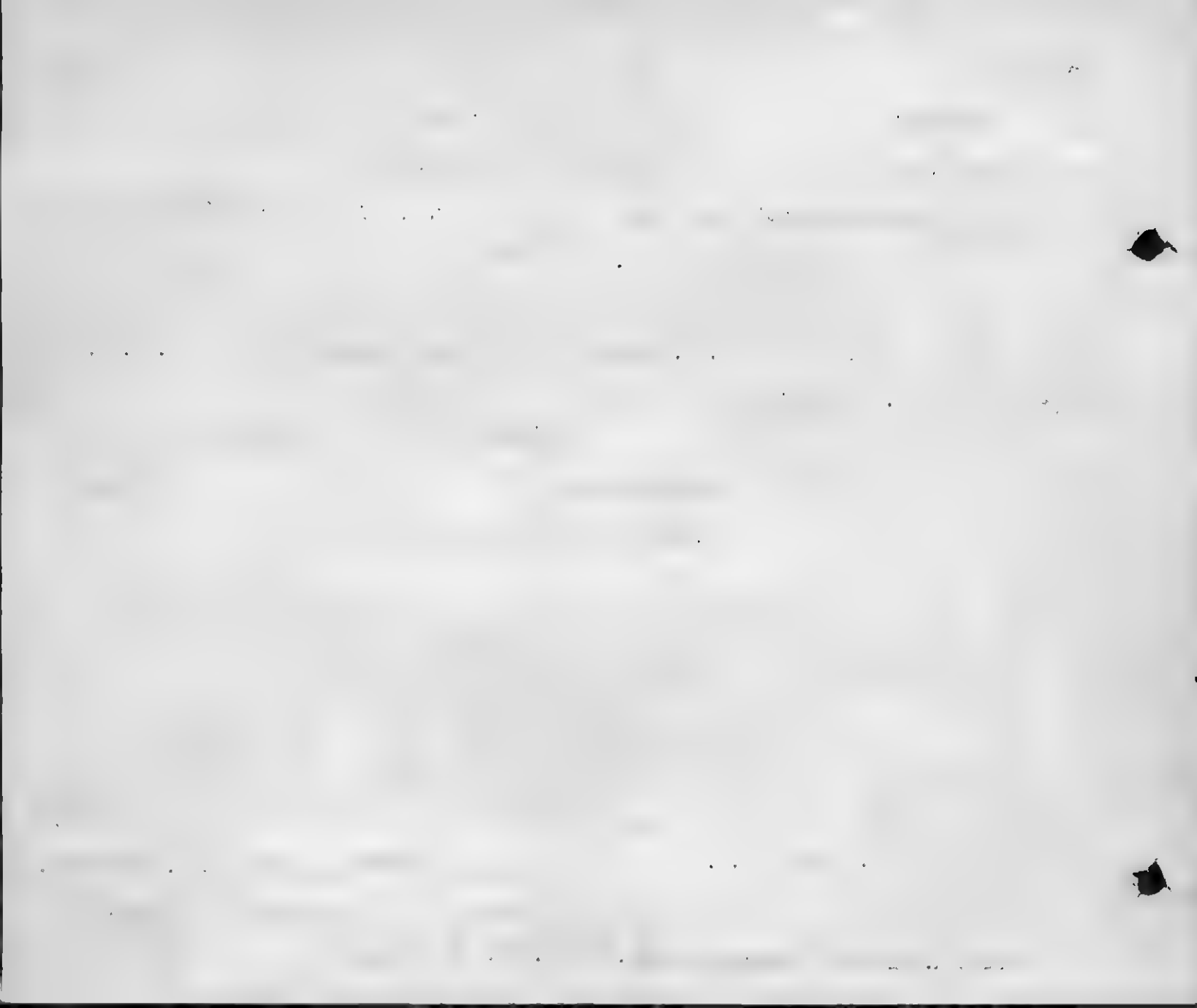


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06559
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN I.B. 6 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2511 W. Baltimore Street (23) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JEROME E. SUMMERVILLE		4. DATE OF DEATH June 18 19 61	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1917
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR: Months 18 Days 19 Hours 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carrier - Mail		10b. KIND OF BUSINESS OR INDUSTRY U. S. Postal	
11. BIRTH-PLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Summerville		14. MOTHER'S MAIDEN NAME Emma Henson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOC. A. SECURITY NO. WW II	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		Address Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) CHRONIC PYELONEPHRITIS WITH UREMIA (c) UNKNOWN (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from June 12 19 61 to June 18 19 61 , that (X) (we) last saw the deceased alive on June 18 19 61 , and that death occurred at 5:39 PM from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 6/19/61	
22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/22/1961	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Katie R. Williams		25a. REC'D BY REGISTRAR DATE JUN 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

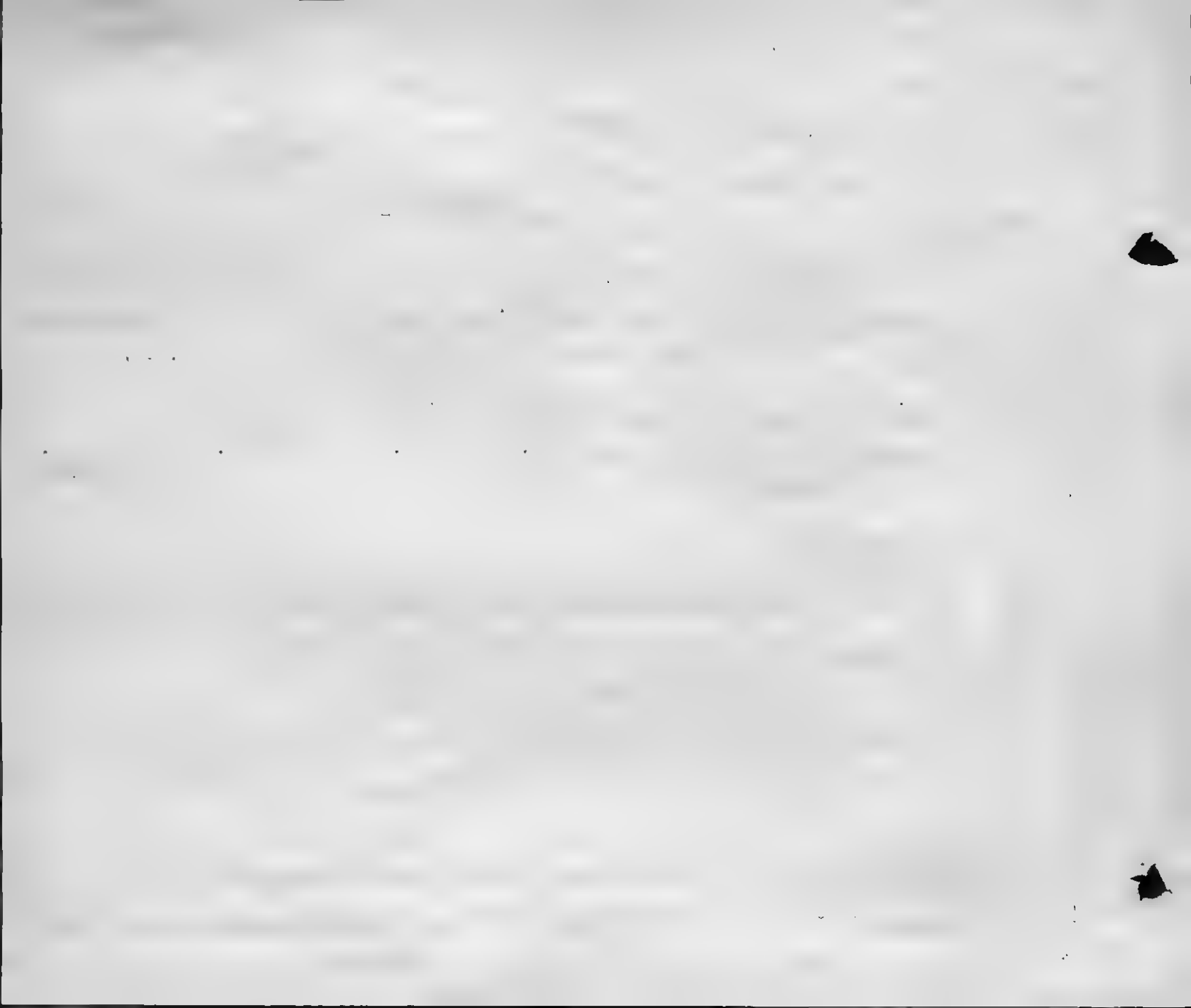
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6578

06560

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EDGE MERE c. LENGTH OF STAY IN IS MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 774 S. Woodington Rd d. STREET ADDRESS Baltimore-29, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Shannon Middle Lee Last Trainer		4. DATE OF DEATH Month 6 Day 17 Year 1961	
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1926
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 6 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles P. Trainer		14. MOTHER'S MAIDEN NAME Grace L. ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW # II		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Mildred J. Trainer-774 S. Woodington Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ix			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently hanged self from beam on pier		20c. TIME OF INJURY Month, Day, Year 6/17/61 Hour a.m. 9:00 p.m. 9:00	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) dock	
20f. (City or town) Edgemere		(County) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King Jr.		DATE SIGNED 6/17/61	
EXAMINER'S NAME (Type) W. Bradley King Jr.		M.D. W. Bradley King Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-61	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or country) Baltimore, Maryland	
23. FUNERAL DIRECTOR Wm J. Tucker & Sons		24a. REC'D BY REGISTRAR Wm J. Tucker & Sons	
24b. DATE JUN 19 '61		24c. REGISTRAR'S SIGNATURE Wm J. Tucker & Sons	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6577

06561

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>600 Martin Blvd.</u>		d. STREET ADDRESS <u>600 Martin Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Newton</u> Last <u>Truitt</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Lorenzo Truitt</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Dorothy C. Truitt</u> Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Cor pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Renal calculus (aggravating factor)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> to <u>6/17</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/17</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> a.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>D. Clark Holmes</u>		22b. DATE SIGNED <u>6/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Clark Holmes</u>		22d. ADDRESS <u>8019 Philadelphia Road, Baltimore 6, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>6-21-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>JUN 20 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

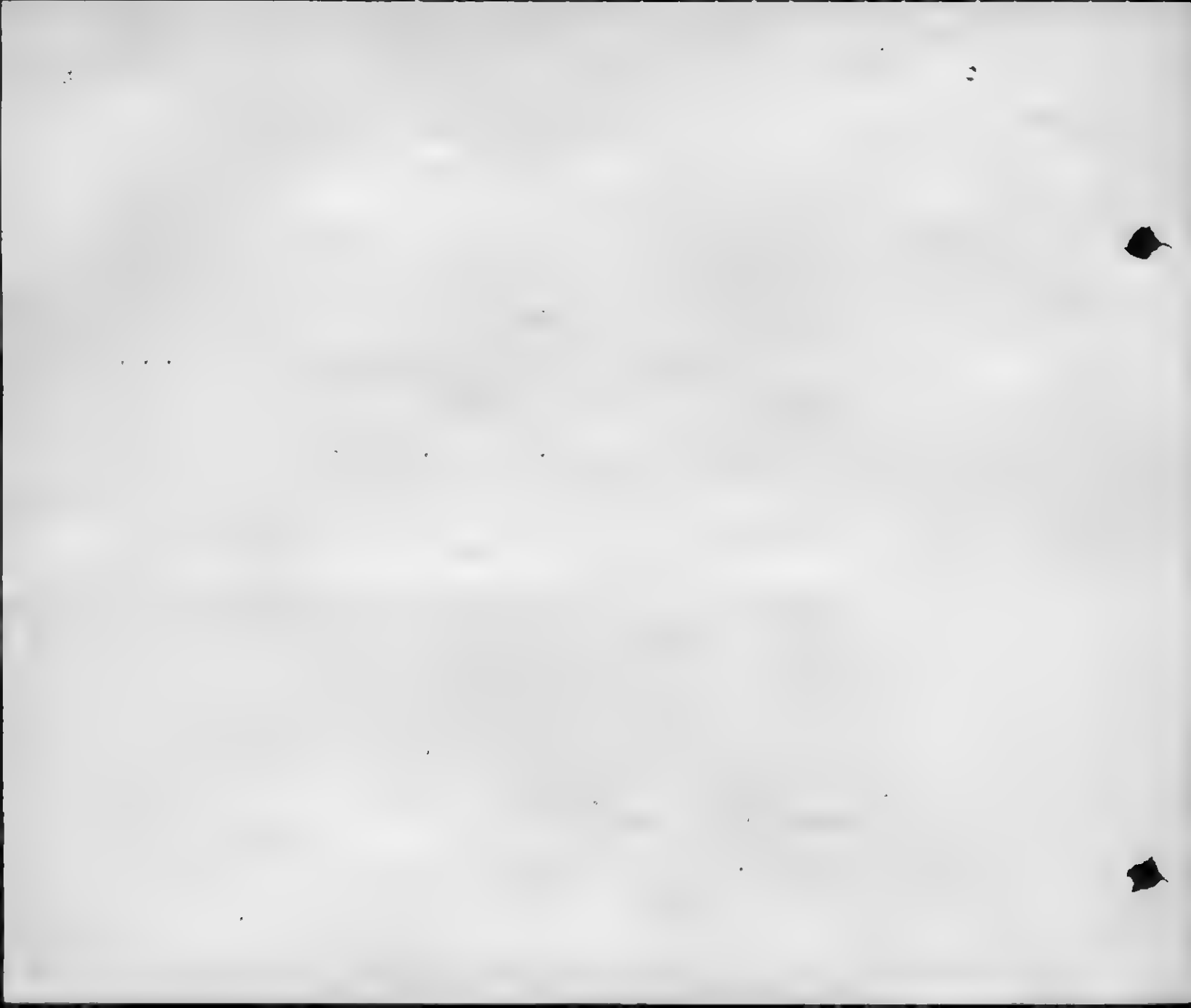
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3001-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Catonsville Nursing Home</u>		d. STREET ADDRESS <u>3934 Norfolk Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Sidney Turpin</u>		4. DATE OF DEATH Month <u>June</u> , Day <u>6</u> , Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Owen Troy Wharton</u>		14. MOTHER'S MAIDEN NAME <u>Angeona ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Sidney G. Turpin-3934 Norfolk Avenue</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho pneumonia Bacterial</u> <u>by</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/12/57</u> to <u>6/6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff, Jr.</u>		22b. DATE SIGNED <u>8/12/57</u>	
22c. PHYSICIAN'S NAME (Type) <u>Cliff Ratliff, Jr.</u>		22d. ADDRESS <u>4675 Edmondson Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-3-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tuckman & Sons</u>		25. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	



1
FOR STATE
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

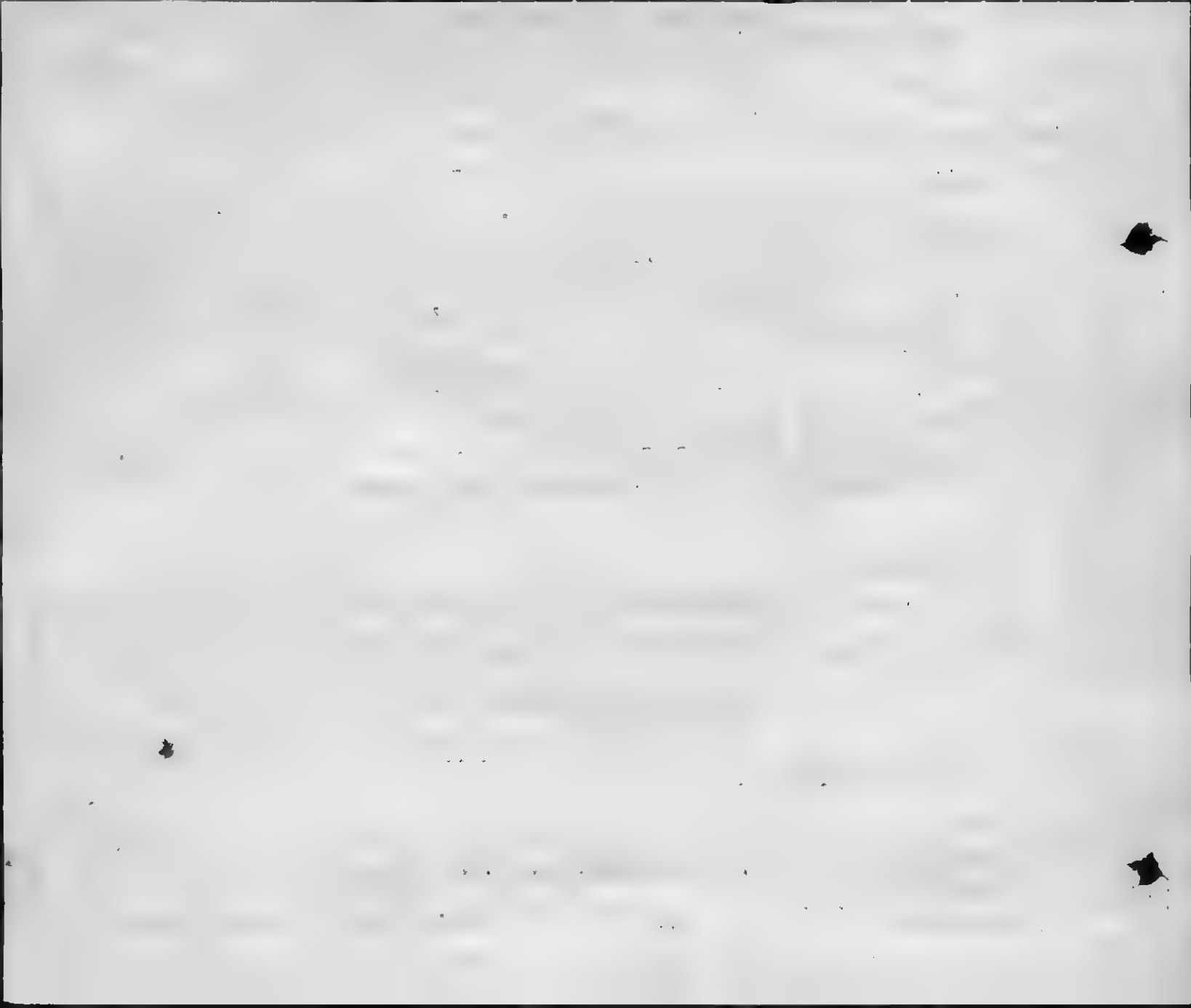
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MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Rosedale c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5822 Shadyside Lane (Shady Spring Ave.)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Rosedale d. STREET ADDRESS 5822 Shadyside Lane /	
3. NAME OF DECEASED (Type or print) JOSEPH CHARLES VLACH (Vlach)		4. DATE OF DEATH Month June Day 23 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Department Store	9. AGE (In years last birthday) 35 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph James Vlach		14. MOTHER'S MAIDEN NAME Josephine Catherine Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 219-10-9626	
17. INFORMANT Joseph J. Vlach		Address 5822 Shady Spring Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			
200 DUE TO (b) 200			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		DATE SIGNED 6/23/61	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-61	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or country) (State) Baltimore-Maryland	
23. FUNERAL DIRECTOR Philip E. Cvach		ADDRESS 1211 Chesaco Ave. Zone 6	
24a. REC'D BY REGISTRAR JUN 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 12 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

6580
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06564

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr7mth18dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1214 Riverside Avenue	
3. NAME OF DECEASED (Type or print) First Florence Middle Bridgette Last Vogelsang		4. DATE OF DEATH Month 6 Day 11 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1879
9. AGE (In years lost birthday) yrs. 81		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Hoben (James Hoben)		14. MOTHER'S MAIDEN NAME Brigette Lockford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 5, 1961 to June 11, 1961 that (I) (we) last saw the deceased alive on June 11, 1961 , and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Blanca Gimenez		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> June 11/61 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Blanca Gimenez		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-15-61	
23c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		23d. LOCATION (City, town, or county) (State) Bethel, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE McCally Funeral Home		25a. RECD BY REGISTRAR DATE JUN 13 '61	
ADDRESS 130 E. Fort Ave		25b. REGISTRAR'S SIGNATURE Arthur L. Haines	



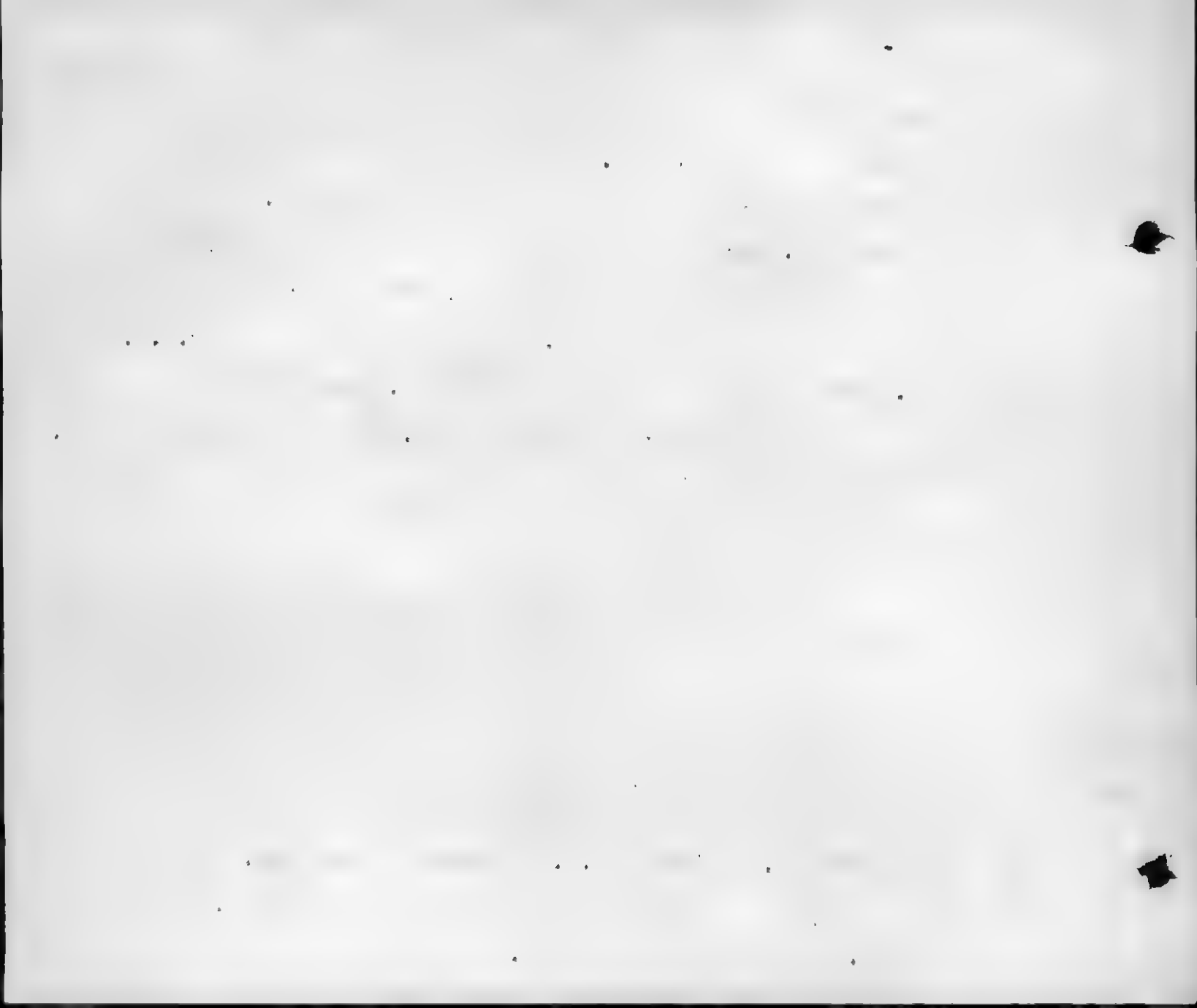
C581

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06565

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b 5 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1111 Elmridge Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
f. STREET ADDRESS 1111 Elmridge Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gordon A. Voyce				4. DATE OF DEATH June 2, 1961			
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH March 5, 1907	
9 AGE (In years last birthday) 54 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Hackert Const.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Voyce				14. MOTHER'S MAIDEN NAME Bridgid T. Herbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16 SOCIAL SECURITY NO 215-10-9376		17 INFORMANT Margaret E. Voyce Address 1111 Elmridge Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung, right (post-operative 2 months) DUE TO (b) 162 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 8 m.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Nov. 20, 1959 to June 2, 1961 ; that (I) (we) last saw the deceased alive on June 2, 1961 and that death occurred at 12:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE R. M. Cunningham M.D. M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Raymond M. Cunningham M.D.				22d. ADDRESS Medical Arts Bldg.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6/5/61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City town or county) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Ambrose Inc. 1328 Sulphur Spring Rd.				ADDRESS		25a REC'D BY REGISTRAR JUN 6 '61 DATE	
				25b REGISTRAR'S SIGNATURE Arthur S. Knead			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



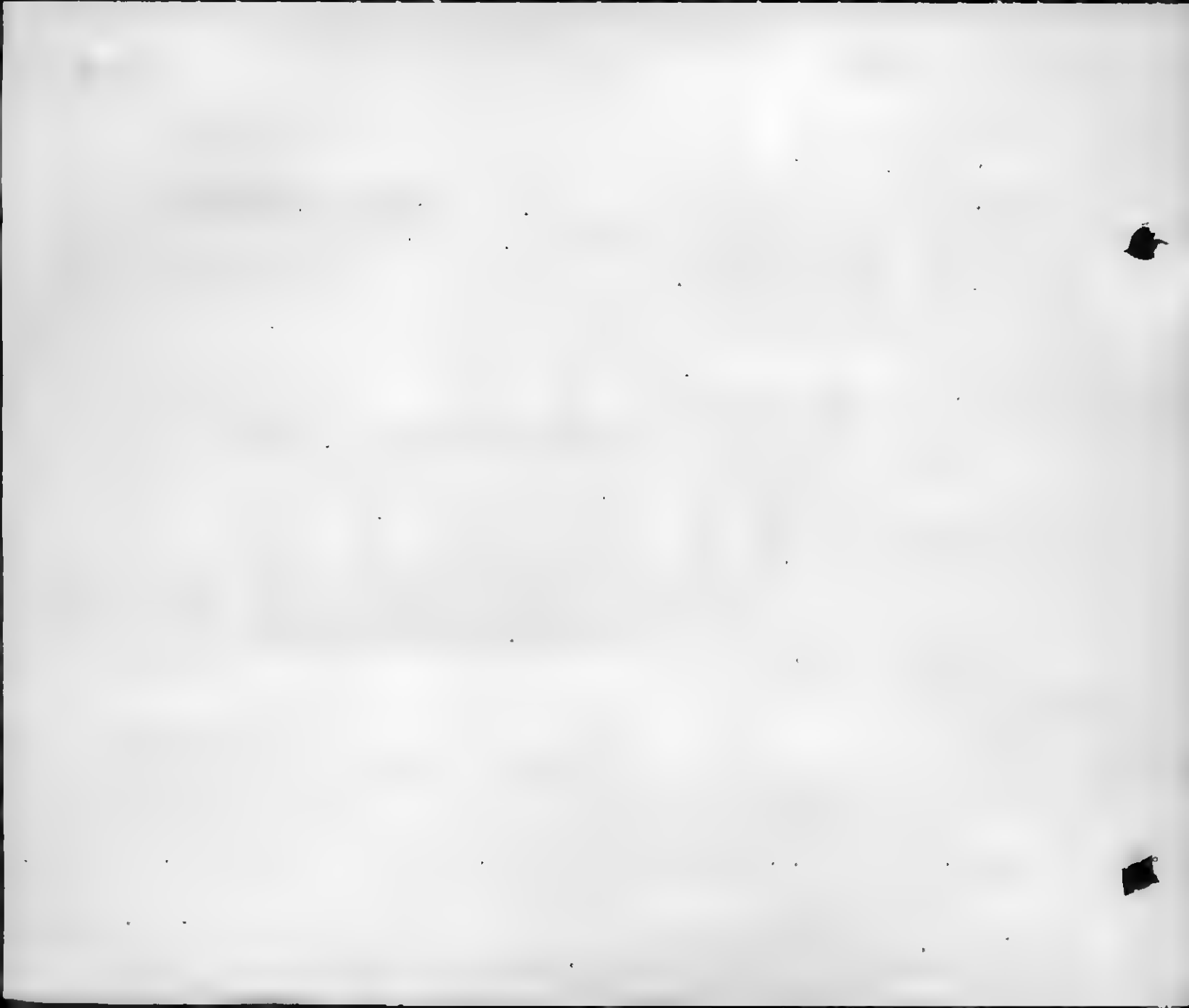
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6582

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06566

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5408 BIDDISON AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK First MILTON Middle WAGNER Last				4. DATE OF DEATH Month 6 Day 14 Year 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-1894	
9. AGE (In years last birthday) 61 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MICHAEL (?)		14. MOTHER'S MAIDEN NAME PAULINE (?)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown	
16. SOCIAL SECURITY NO. 213-18-6054		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of sigmoid colon with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 year DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis. Emphysema							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 002X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 5-13-1961 to 6-14-1961 , that (I) (we) last saw the deceased alive on 6-14-1961 and that death occurred at 1:56 from the causes and on the date stated above.	
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 6.14.1961		22c. PHYSICIAN'S NAME (Type) W. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/61		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Weber		25a. REC'D BY REGISTRAR JUN 19 '61		25b. REGISTRAR'S SIGNATURE Robert L. Thomas		25c. ADDRESS 401 S. Chester St.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6583

Item 20b, telephone call from Tickner's Office

66567

6/7/61.c

1. PLACE OF DEATH
a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville c. LENGTH OF STAY IN It MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home in the Pine-17 Easting Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville d. STREET ADDRESS 1000 Middle Place

3. NAME OF DECEASED (Type or print) Nannette E. Waltemeyer 4. DATE OF DEATH June 8, 1961 19 19

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Nov. 3, 1987 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Retired 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John T. Waltemeyer 14. MOTHER'S MAIDEN NAME Mary J. ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 705-25-3112 17. INFORMANT Mrs. Briggs-1000 Middle Place Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cerebrovascular Syndrome
334X DUE TO
Conditions, if any, which gave rise to immediate cause (b) 1 1/2 yrs
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 1950 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/8, 19 61, to 6/8, 19 61, that (I) (we) last saw the deceased alive on 6/8, 19 61, and that death occurred at 5AM, from the causes and on the date stated above.

22a. SIGNATURE Edward S. Kallins M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED _____

22c. PHYSICIAN'S NAME (Type) Edward S. Kallins 22d. ADDRESS 1300 Liberty Heights Avenue

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6-17-61 23c. NAME OF CEMETERY OR CREMATORY North & Anna Aves 23d. LOCATION (City, town or county) (State) Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Harry Tickner, Jr. 25a. REC'D BY REGISTRAR DATE JUN 9 '61 25b. REGISTRAR'S SIGNATURE Edward S. Kallins



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

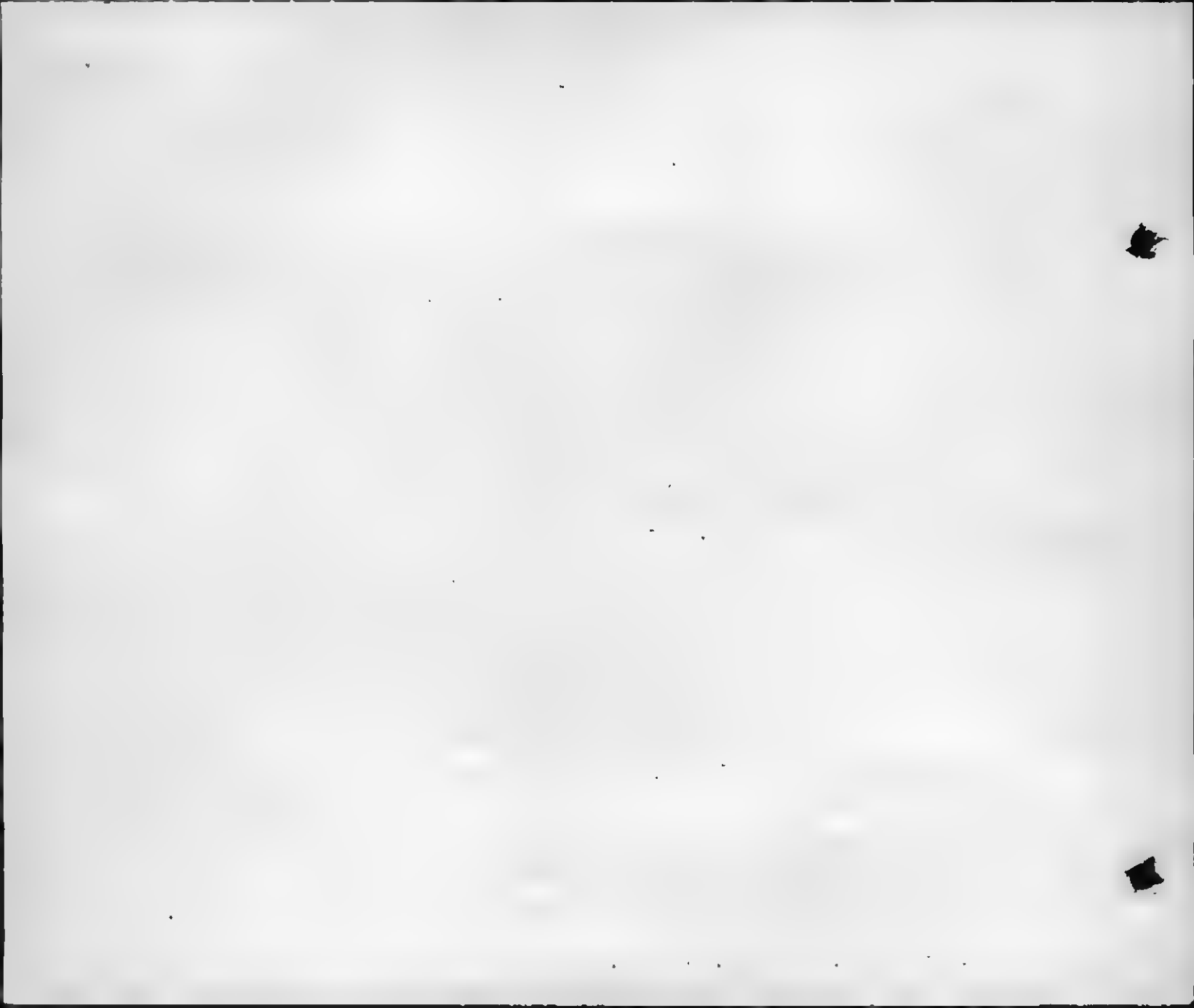
6584

66568

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 13 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 17x-		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA CROSWELL WHITE				4. DATE OF DEATH Month Day Year JUNE 8 1961			
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM W CROSWELL				14. MOTHER'S MAIDEN NAME LAVINA HASTINGS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Frank L. Smith Jr. - Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4115 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension Arterio Sclerotic Cardiac DUE TO (c) Vascular diseases INTERVAL BETWEEN ONSET AND DEATH 10 years.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-6 19 61 to 6-7 19 61 , that (I) (we) last saw the deceased alive on 6-7 19 61 and that death occurred at 7:25 AM , from the causes and on the date stated above.							
22a. SIGNATURE Walter T. Kee		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6/8/61			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEE		22d. ADDRESS COCKEYSVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF June 11, 1961		23c. NAME OF CEMETERY OR CREMATORY All Saints Churchyard		23d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St.				25a. REC'D BY REGISTRAR DATE JUN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hearn	

MEDICAL CERTIFICATION

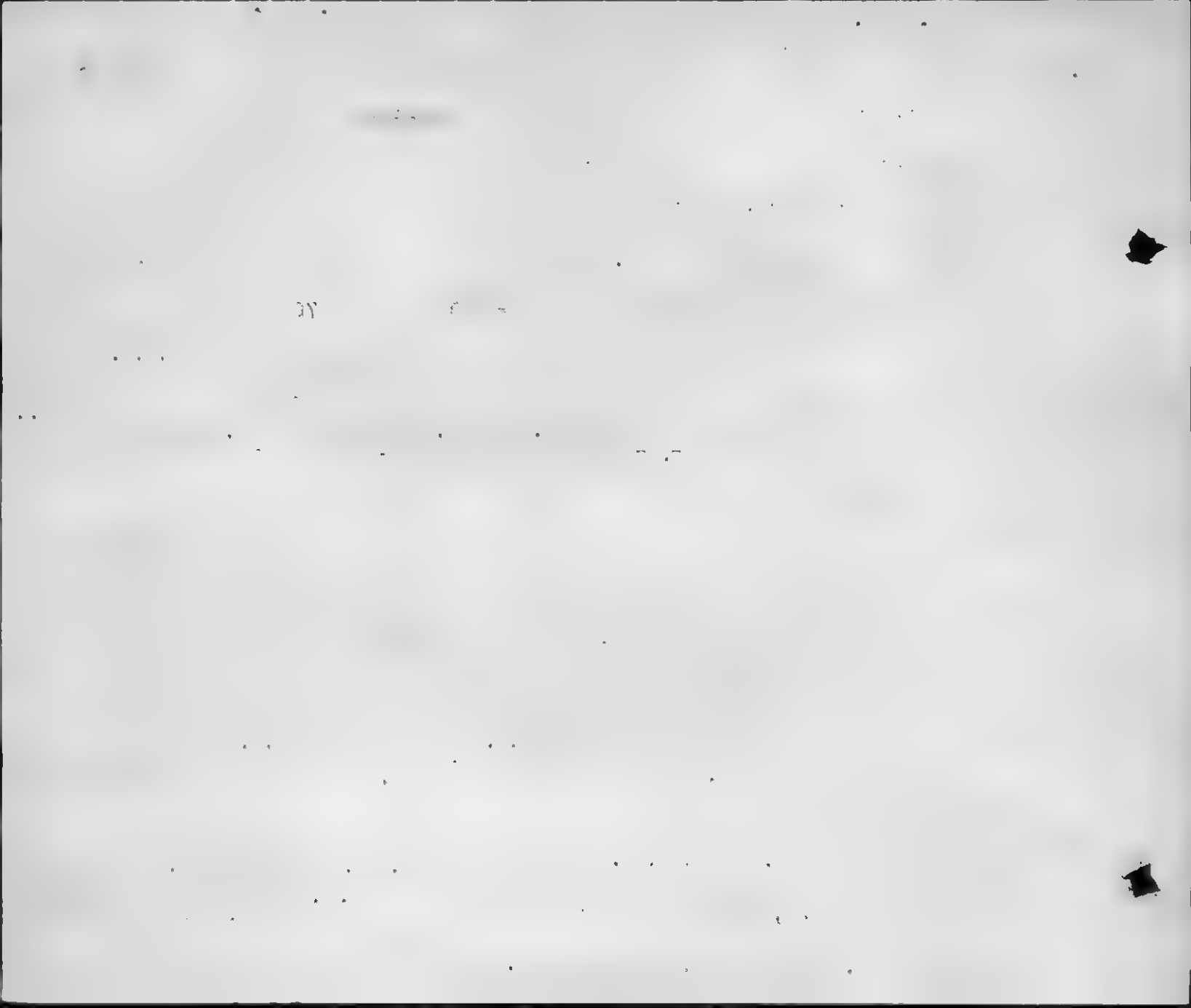


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06569

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN TB 6-1/2 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Delaware b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seaford d. STREET ADDRESS 41X - 2	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last WHITE		4. DATE OF DEATH Month June Day 2, Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-7-96	
9. AGE (in years) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Produce	
11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver S. White		14. MOTHER'S MAIDEN NAME Betsy Jane Fletcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 226-28-9956	
17. INFORMANT Mrs. Sara L. Beard (Sister)		Address P. Box #302 Seaford Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X EDEMA OF THE LUNGS DUE TO (b) CARDIAC HYPERTROPHY AND DILATION DUE TO (c) AORTIC AND MITRAL INSUFFICIENCY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4. PASSIVE CONGESTION LUNGS, LIVER AND SPLEEN		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 61 Hour a.m. p.m. 12:30 P.M.		20d. INJURY OCCURRED 12:30 P.M.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTO. MD. FT HOWARD DIV.		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 2, 19 61 to June 2, 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 2, 19 61 and that death occurred at 7:00 P.M. from the causes and on the date stated above.		22a. SIGNATURE Norman P. Jones M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6/3/61	
22c. PHYSICIAN'S NAME (Type) NORMAN P. JONES, M. D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Jun. 6, 1961	
23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		23d. LOCATION (City, town or county) (State) R.D.# Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Funeral Home, Salisbury, Md.		25a. REC'D BY REGISTRAR DA JUN 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. DATE 6/3/61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6586
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATON RIDGE HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>1400 CHALFONTE DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>JOSEPH L. WHITTY</u>	4. DATE OF DEATH <u>6/15</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/88</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police ret.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	11. BIRTH-PLACE (County & State, or foreign country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>NICHOLAS WHITTY</u>				14. MOTHER'S MAIDEN NAME <u>MARIE CARRIGAN</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARK E. CARRIGAN</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>age</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Bed Sores</u>						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	21. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> , 19 <u>61</u> to <u>6/15</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>6/14</u> , 19 <u>61</u> , and that death occurred at <u>9:20</u> PM, from the causes and on the date stated above.		
22a. SIGNATURE <u>Curt Kautz</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>4605 EDMONDSON AVE</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
<u>Burial</u>		<u>6/19/61</u>		<u>Lorraine</u>		<u>Woodlawn Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donna Stott + son</u>		ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				DATE <u>JUN 20 '61</u>		<u>Charles S. Hanna</u>		



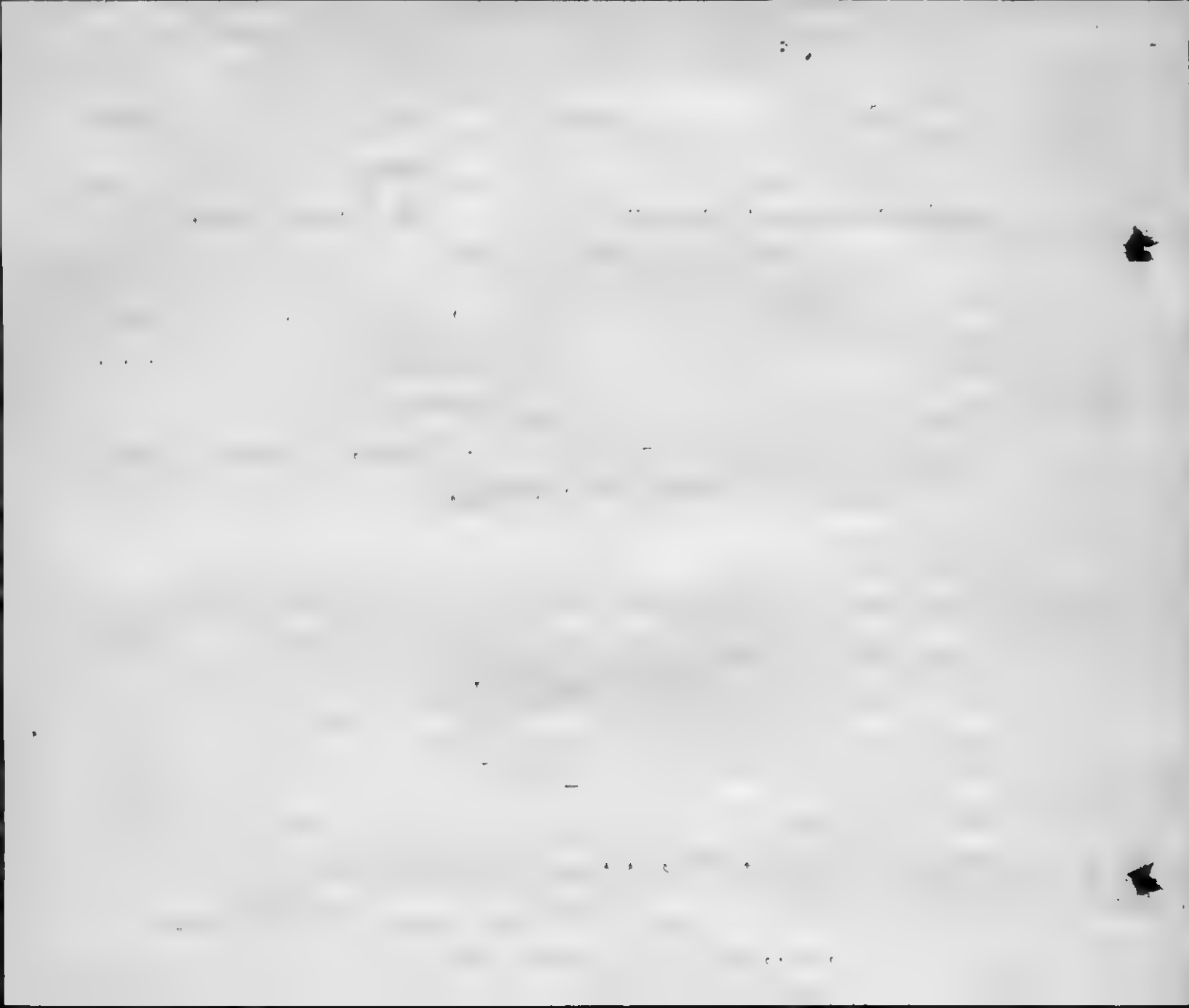
1
FOR STATE
HEALTH DEPT.

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
06571														
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Providence Road near Loch Raven					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 8700 Loch Bend Drive. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last WICK					4. DATE OF DEATH Month June Day 24 Year 19 61									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1904		9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME John Wick					14. MOTHER'S MAIDEN NAME Helen White									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. 216-03-4030					17. INFORMANT Robert L. Johnson, 3022 Overland Avenue Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Abdomen. DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in abdomen. 20c. TIME OF INJURY Month, Day, Year 6/24 19 61 Hour xxx p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road 20f. (City or town) Towson (County) Baltimore (State) Md.										INTERVAL BETWEEN ONSET AND DEATH				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/25/61									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-28-61		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or country) Baltimore (State)								
23. FUNERAL DIRECTOR Wm. Cook-Blight, Inc., 6009 Harford Road ADDRESS						24a. REC'D BY REGISTRAR JUN 28 '61 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Hume						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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6585

CERTIFICATE OF DEATH

06572

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Mass. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newton Center	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 607 Piccadilly Road		d. STREET ADDRESS 83 Norwood Road	
3. NAME OF DECEASED (Type or print) LOUISE SLAYTON WILLARD		4. DATE OF DEATH June 15, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1886
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Charles Fremont Slayton		14. MOTHER'S MAIDEN NAME Gertrude Lancaster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Decompensative Cardiovascular Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from May 28, 1961 to June 15, 1961 , that (I) (we) last saw the deceased alive on June 15, 1961 , and that death occurred at 1:30 PM , from the causes and on the date stated above. 21a. SIGNATURE Laurence C. Post 21b. DATE SIGNED 6-16-61 22a. PHYSICIAN'S NAME (Type) LAURENCE C. Post 22b. ADDRESS 6805 York Rd, Baltimore 12 Md 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF June 16, 1961 23c. NAME OF CEMETERY OR CREMATORY Short & Williamson Funeral Home 23d. LOCATION (City, town or county) (State) Boston, Mass 24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland 25a. REC'D BY REGISTRAR JUN 23 1961 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

22

1. The first part of the report

is devoted to a general survey of the

main results of the investigation

and to a comparison of the results with

the results of other investigations

and to a comparison of the results with

the results of other investigations

and to a comparison of the results with

the results of other investigations

and to a comparison of the results with

the results of other investigations

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

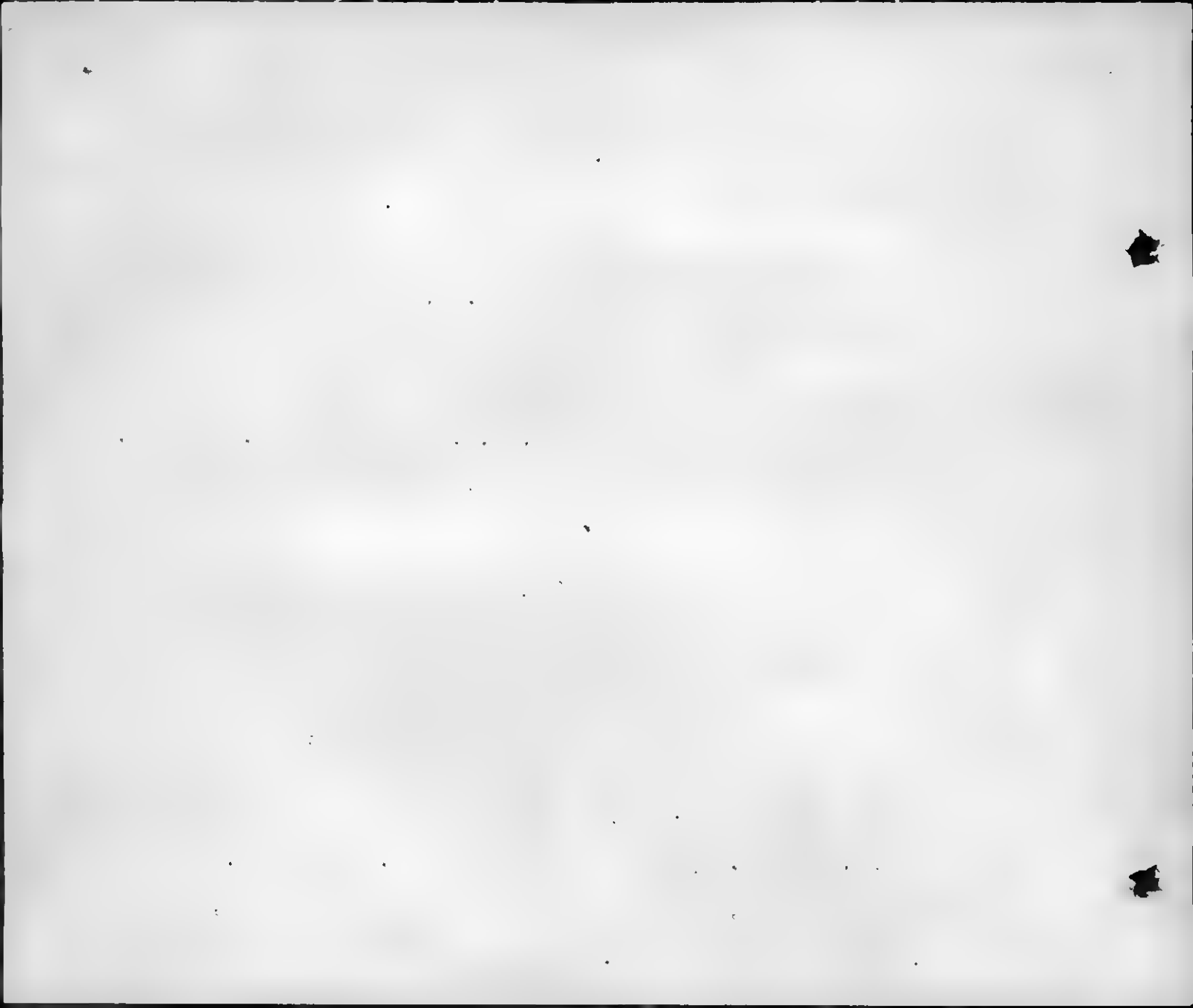
VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06573

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.	
c. LENGTH OF STAY IN 1b Greenspring Ave., Owings Mills, Md.		d. STREET ADDRESS Greenspring Ave. Rt #1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greenspring Ave., Owings Mills, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clement Vivian Wolfe		4. DATE OF DEATH June 29, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1903	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Veterans Admin.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Wolfe		14. MOTHER'S MAIDEN NAME Izetta Blevins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service) Yes W.W. 11		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Earline B. Wolfe, Greenspring Ave.		Address Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO (b) Aricular Fibrillation DUE TO (c) Angina Pectoris PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 6 mos. 6 mos.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. D.D. Caples, Reisterstown, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1961	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Frank H. Newell, Baltimore, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

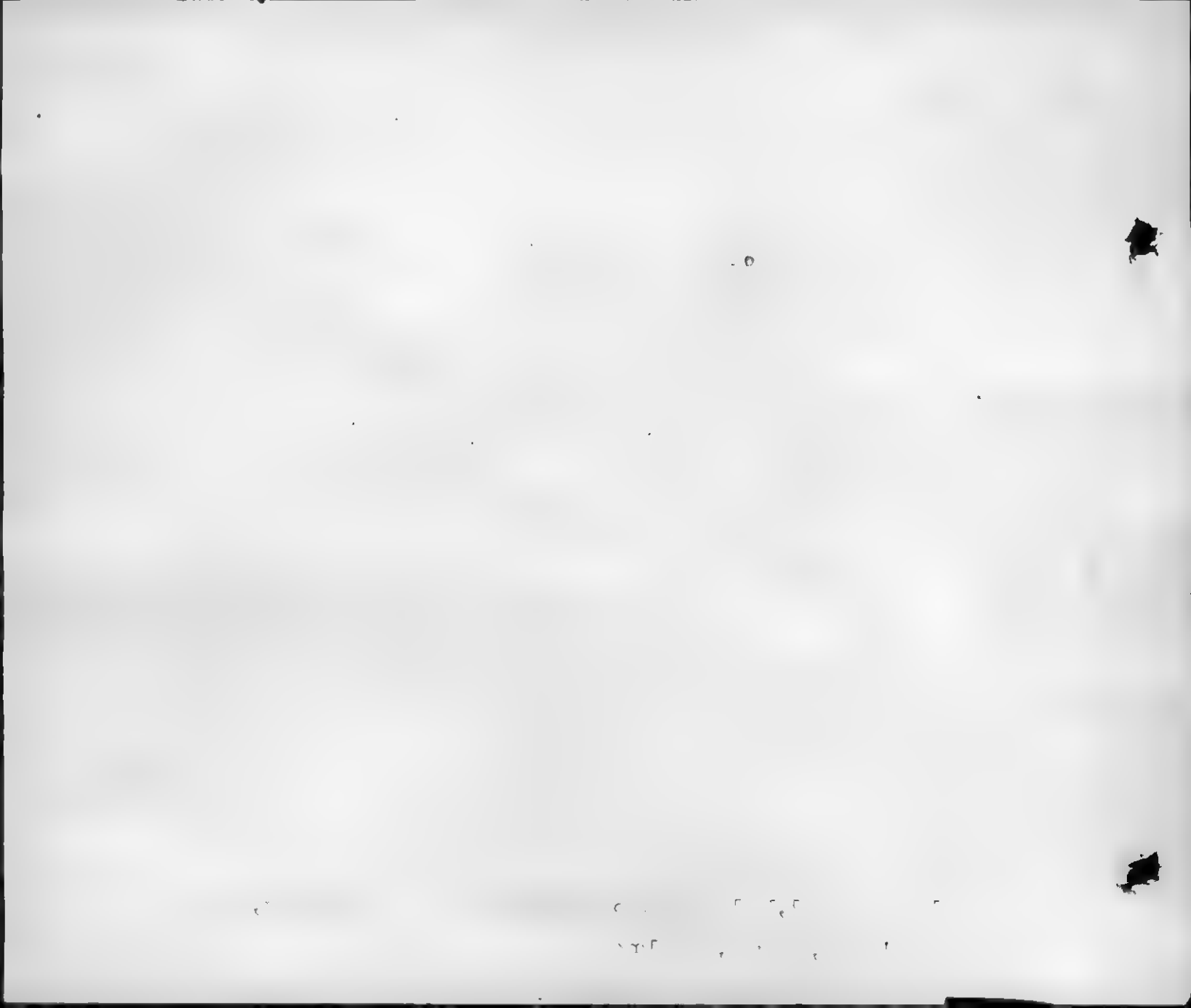
VR A15 (4)
15M 9/59

1
6591
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06575

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. STREET ADDRESS <u>10641 Lehigh Ave</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Caroline Roberta Woods</u>				4. DATE OF DEATH Month Day Year <u>June 28 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1887</u>	9. AGE (In years lost birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NO</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Robert Woods</u>				14. MOTHER'S MAIDEN NAME <u>Alice Spilker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Emmett Woods per Dr. Franklin E. Leslie</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of stomach</u> <u>151X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 19 1961</u> to <u>June 28 1961</u> , that (I) (we) last saw the deceased alive on <u>June 27 1961</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Franklin E. Leslie</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie</u>				22d. ADDRESS <u>2424 N. Market ST</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUL 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Puma</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6592

CERTIFICATE OF DEATH

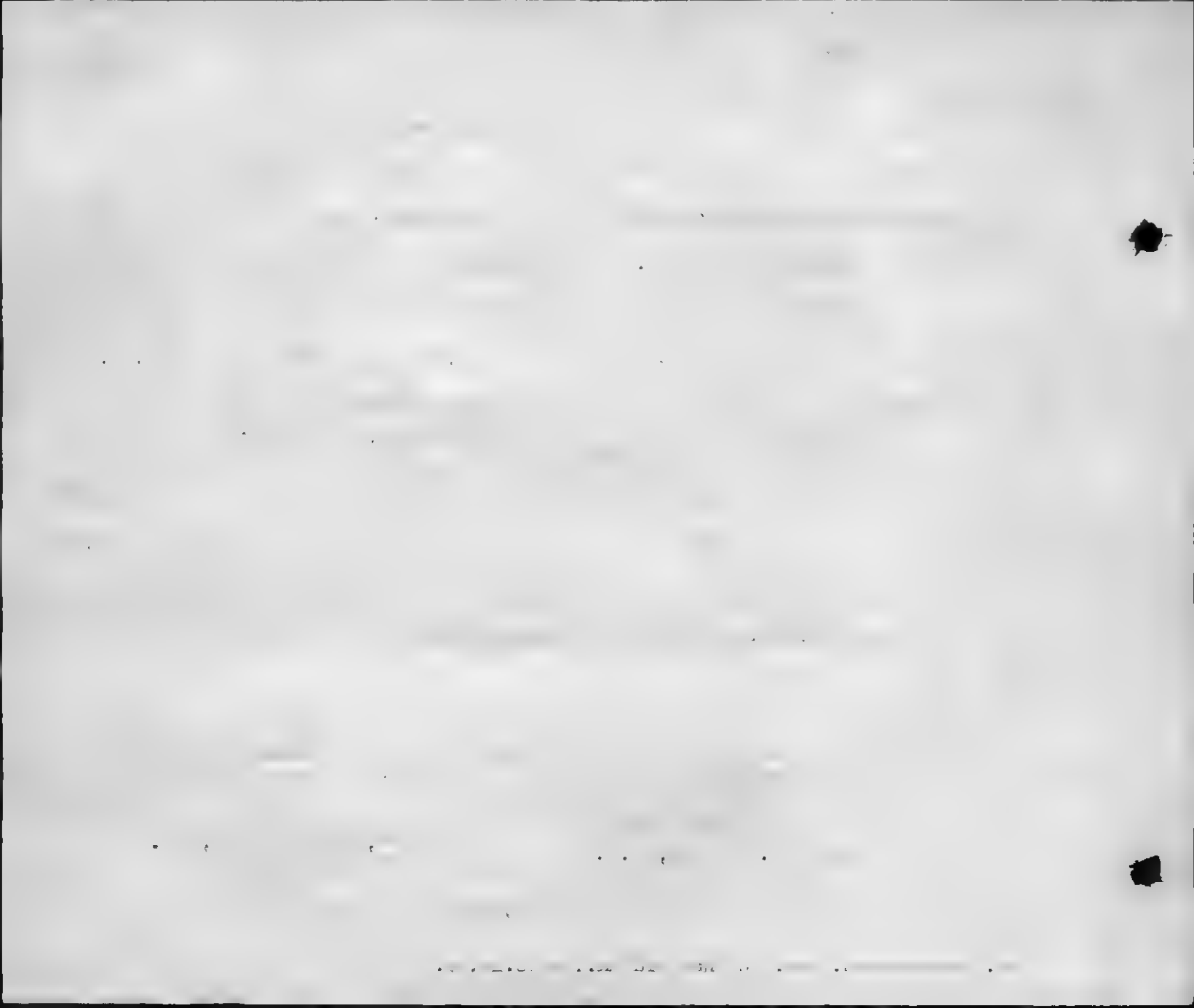
06576

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard		c. LENGTH OF STAY IN 1b 3 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21 (Hyde Park 21)		d. STREET ADDRESS 1448 Galena Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Veterans Administration Hospital												4. DATE OF DEATH Month June Day 19 Year 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 19, 1907		9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10b. KIND OF BUSINESS OR INDUSTRY Trucking				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Alfred Woolley				14. MOTHER'S MAIDEN NAME Louise Wagner				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WW II				16. SOCIAL SECURITY NO. 216-07-5391							
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPHYSEMA												INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
DUE TO (b) ASTHMA												DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
ARTERIOSCLEROTIC HEART DISEASE - DURATION UNKNOWN												20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:45 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from June 16, 1961 , to June 19, 1961 that (we) last saw the deceased alive on June 19, 1961 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE <i>Thomas F. Crahan</i>												22b. DATE SIGNED 6/19/61							
22c. PHYSICIAN'S NAME (Type) Thomas F. Crahan, M.D.												22d. ADDRESS VAH, Baltimore 18, Md. Fort Howard Division							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-22-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.								25a. REC'D BY REGISTRAR DATE JUN 21 '61								25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06577

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Towson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>6307 Bellona Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Lee Wright</u>		4. DATE OF DEATH Month Day Year <u>June 20 19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry DeSheilds Seim</u>		14. MOTHER'S MAIDEN NAME <u>Josephine B Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Edwin F. Wright</u>		Address <u>6307 Bellona Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 42-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mel.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6 1960</u> , to <u>June 20 1961</u> , that I last saw the deceased alive on <u>June 20 1961</u> , and that death occurred at <u>4:15 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D.		ADDRESS (Street, city or town, state) <u>6805 York Rd. Baltimore 12 Md</u>	
DATE SIGNED <u>6-20-61</u>			
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 23 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Harwood</u>		ADDRESS <u>204 Ridgewood Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06578

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHASE MD.		c. LENGTH OF STAY IN 1b 13 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHASE MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 398 NORTH RIVER DRIVE #20		d. STREET ADDRESS Box 398 NORTH RIVER DRIVE #20		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA G. ZOLLER		4. DATE OF DEATH 6 14 1961		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/1886	
9. AGE In years (last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHRISTIAN HEARN		14. MOTHER'S MAIDEN NAME SALLY RHODES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. NONE		17. INFORMANT William ZOLLER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardio-Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH ---		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---		20g. (County) ---		20h. (State) ---	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M-B Davis		M.D. M-B DAVIS MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M-B DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/17/61		22c. NAME OF CEMETERY OR CREMATORY MORELAND MEM PARK	
22d. LOCATION (City, town, or country) BALTIMORE		22e. (State) MARYLAND		22f. (Country) ---	
23. FUNERAL DIRECTOR Louisa Funeral Home		23a. ADDRESS 7401 Belair Rd #6		23b. REC'D BY REGISTRAR JUN 19 1961	
23c. REGISTRAR'S SIGNATURE Arthur S. Kraus		23d. DATE 6/17/61		23e. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2 & 12 Film G288 6/15/61 iwk

CERTIFICATE OF DEATH

6595

Reg. Dist. No.

06579

1. PLACE OF DEATH a. COUNTY Balto. 28, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home				d. STREET ADDRESS 215 W. Lorraine Ave. Summit & Smithwood Ave.			
3. NAME OF DECEASED (Type or print) First Annie C. Zorio Middle Last				4. DATE OF DEATH Month June Day 8 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1884	9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cefalu' Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Santo Catanese			
14. MOTHER'S MAIDEN NAME Teresa Rosso				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Annie L. Salmeri 3104 W. Garrison Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 334x Generalized Arterio Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Residual of Multiple Strokes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) 6/8/61				(County)		(State)	
21. I certify that I attended the deceased from 6/7/61 to 6/8/61 , that I last saw the deceased alive on 6/7/61 , and that death occurred at 2:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md DATE SIGNED 6/9/61 ACTUAL SIGNATURE W. E. Mc Grath M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/61		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) Old Frederick Road	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Farace Inc. 712-14 E. North Ave.				24a. REC'D BY REGISTRAR DATE JUN 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 2 - Film G208 6/15/61 iwk											
6596											
06580											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>60 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph's Conv. Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (30) Md.</u> d. STREET ADDRESS <u>1221 Carroll St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Bois Zwickas</u>						4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1891</u>		9. Age (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>						16. SOCIAL SECURITY NO. <u>215-14-9369 MR. Joseph Dash</u>					
17. INFORMANT <u>337 Whitfield Rd.</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO <u>Arteriosclerotic cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (c) <u>cerebral Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12, 1961</u> to <u>June 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 2, 1961</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Justinas Kudirka</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Justinas KUDIRKA</u>						22d. ADDRESS <u>2151 Wilkens Ave, Balt. Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>6-6-61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cmt</u>			23d. LOCATION (City, town or county) <u>BALTIMORE</u> (State) <u>Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dabrowski</u>						ADDRESS <u>284 E. Baltimore St.</u>			25a. REC'D BY REGISTRAR <u>Arthur S. Knaus</u>		
						DATE <u>JUN 12 '61</u>			25b. REGISTRAR'S SIGNATURE		

68327

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(M)

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(I)